UNIVERSITA' DI PISA

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Corso di laurea magistrale in Giurisprudenza

Born in the U.K. and in the U.S.A.:

heterologous fertilisation and surrogacy in Common Law Countries

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A.A. 2014/ 2015

"The reasonable man adapts himself to the world: the unreasonable one persists in trying to adapt the world to himself. Therefore all progress depends on the unreasonable man."

George Bernard Shaw, Man and Superman (1903)

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INTRODUCTION

One would think that the common origin of America and England in jurisprudence would determine similar choices for both countries in Case Law. However their approach to Common Law is as divided as the Ocean that separates them.

Their diverse historical and cultural developments have produced two countries with significant contrasts, including vastly differing legal systems.

In the following text the differences between the English and the American approach towards the evolving theme of assisted fertilization techniques will be demonstrated. Particular attention will be focused on heterologous fertilisation and surrogate maternity as it is these two aspects that pose the most legal questions when discussing the relationship to the unborn child. Initially the English legal system's approach will be examined, followed by close examination of the American jurisprudence.

The historical development of English law regarding the theme of assisted fertilisation will then be discussed with special regard to situations that impacted on the course of the legislation. A more detailed examination will also be provided of the legal aspects of individual fertilisation techniques, including the more significant legal cases.

The study of the United States legislation follows, beginning with a constitutional analysis of the essential right of any Federal or State legislation of this country, the Right to Privacy.

Moving on to an examination of the existing scant Federal legislation, the study then proceeds with an analysis of legislation in several individual states. The 50 American States have the freedom to legislate independently on different areas of jurisprudence, which

includes the right to conceive. It was essential to select those states that provided the best examples for reflection regarding heterologous fertilisation techniques and surrogate maternity.

At this point the discussion is conducted on two parallel planes. Having identified which State's legislation is to be examined, each States' legislators' answers to the questions of development of these new reproductive frontiers is presented. The legal and judicial activities of the two States selected California and Massachusetts, were studied in depth, and whilst geographically they are very distant they both have a rather open approach, and in some aspects are not all that different.

THE UNITED KINGDOM APPROACH TO THE ASSISTED REPRODUCTION

In 1973 an Australian couple tried to conceive a baby with Artificial Reproduction Technique (ART), but the pregnancy was not successful because of the premature death of embryo caused by an ectopic pregnancy.[1]

On 25 July in the United Kingdom Louise Brown was born, the first human being conceived using the technique of "In Vitro Fertilisation" (IVF).

IVF is one of the assisted reproduction techniques offering infertile couples a chance to conceive a child.

The medical dictionary gives the definition of "In Vitro Fertilisation" as a process where eggs are fertilized with sperm outside the body. The technique involves monitoring and stimulating a woman's ovulatory process, removing eggs from the ovaries and letting the sperm fertilize them in a laboratory with the use of a test tube (hence why it is called "test tube baby"). At the end of the procedure the fertilized egg, now an embryo, is returned into the woman's uterus.[2]

This type of fertilisation has continued to be successfully used since 1978 and has helped thousands of couples who could not have conceived their own child naturally to have their own baby. This technique is widely used today but over the years research and improvements in medicine have established other Assisted Reproduction Techniques (ART).

1 http://www.myvmc.com/treatments/in-vitro-fertilisation-ivf/

2 Medical-dictionary, available at: http://www.thefreedictionary.com/

In the UK there are many types of techniques which include the gametes treatment, cryopreservation of gametes and embryos, techniques of sex selection and the use of surgery to modify or re-position the reproductive organs, such as the Reverse Vasectomy that are used. All ART techniques are governed by specific laws in the UK excluding the "DO IT YOURSELF" fertilisation technique where people can try to conceive by themselves with no medical assistance. They may do this by injecting sperm into the uterus, this can be self administered by a woman, or they may use fertility drugs. The In Vitro Techniques in which fertilisation takes place outside of the uterus are controlled and authorised by specific laws (in vitro maturation - gamete into fallopian transfer - intra cytoplasmic sperm injection - intrauterine insemination - embryo testing - reproductive immunology – surrogacy - donation of ova sperm and embryos).[3]

After the birth of Louise Brown in the UK the debate around the Fertilisation Technique became something on which make a legal decision few years later, in 1982, a commission was established to discuss these new possibilities of conception from the legal point of view. This commission was called the Warnock Committee after its President, the philosopher Baroness Mary Warnock.

In the introduction to the Report by the Committee it was stated that:

> *"Against this background of public excitement and concern, this Inquiry was established in July 1982, with the following terms of reference: "To consider recent and potential developments in medicine and science related to human fertilisation and embryology; to consider what policies and safeguards should be applied, including consideration of the social, ethical and legal implications of these developments; and to make recommendations.".*[4]

3 http://www.hfea.gov.uk/fertility-treatment-options.html

4 Report of Warnock Committee at Section. 1.2; 4

The Warnock Committee recommended the adoption of a legislative instrument by Parliament to control the use of Assisted Reproduction Techniques. In fact a direct consequence of the Warnock Report on the Government was the adoption of the Human Fertilisation and Embryology Act 1990.[5]

The Human Fertilisation and Embryology Act 1990 represents a milestone in bio medical regulation, not only because it provided a conclusion to the government discussion about the proper approach to reproductive science, but also because it was the first attempt by English law to make medical science democratically accountable.[6] The Act established the guidelines by which the assisted medical fertilisation and the embryological technique could be realized and at the same time established an independent authority, the Human Fertilisation and Embryology Authority (HFEA) for the supervision of medical treatments associated with developments of the latest technologies developments in this area.

HFEA is an executive non-departmental public body sponsored by the Department of Health. The Authority is composed by eleven members, several are individuals not involved in science or clinical assisted reproduction and it is organized into several sub-committees each dealing with a particular topic. In recent years it has also been used as an instrument for public consultation about important new medical themes.[7]

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5 Carlo Casonato e Tommaso Edoardo Frosini, *La Fecondazione Assistita nel diritto comparato*, Giappichelli Editore, 2006

6 Jonathan Montgomery, *Rights, Restraints and Pragmatism: The Human Fertilisation and Embryology Act 1990*, July 1991

7 P. Passaglia con contributi di E. Bottini, C. Guerrero Picó, S. Pasetto e M. T. Rörig, La Fecondazione Eterologa. Available at: http://www.cortecostituzionale.it/documenti/convegni_seminari/CC_SS_fecondazione_eterologa_201406.pdf

The Human Fertilisation and Embryology Authority has the power to oversee the activities of health practitioners not only when applying the rules established by Parliament but also in creating their own standards as to what is acceptable in these practices. That normative capacity confirms the autonomy of this organ.

The Authority however remains partially under Government control due to some established rules which supervise the exercise of its power.[8]

London's Parliament fixed the limits of what is permissible theoretically, the HFEA however has the difficult task of deciding what at a particular time is permissible whilst considering any relevant scientific improvements (i.e. if it's possible to reach the same goal using other research) and society's position.

This *modus operandi* for the United Kingdom is the right balance between having fixed boundaries and continuing with the evolution of medical science.

Under the Human Fertilisation and Embryology Act, the HFEA is required to give guidance to the licensed centres about "*the proper conduct of activities carried out in pursuance of a license*".

This guidance is online on the HFEA website and is part of the HFEA Code of Practice currently in its 8th edition.[9]

If a licensed clinic infringes the Code it is not considered a crime, but the Authority takes into account this offense and may not renew or revoke an authorization for this medical institute.[10]

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8 Jonathan Montgomery, Rights, Restraints and Pragmatism: The Human Fertilisation and Embryology Act 1990; July 1991

9 http://www.hfea.gov.uk/176.html

10 P. Passaglia con contributi di E. Bottini, C. Guerrero Picó, S. Pasetto e M. T. Rörig., La Fecondazione Eterologa, Available at: http://www.cortecostituzionale.it/documenti/convegni_seminari/CC_SS_fecondazione_eterologa_201406.pdf

The clinics that follow the current Code regulation are included in a directory made by HFEA: it lists the licensed fertility clinics and centres carrying out IVF, other assisted reproduction techniques and human embryo research.

The job of the Authority is to control the work of the UK licensed clinics. They may carry out periodical inspections when necessary with the assistance of expertise in the area.

The Human Fertilisation & Embryology Authority keeps a confidential register of information about donors, patients and treatments.

The register was set up on 1 August 1991 and was created by the Human Fertilisation and Embryology Act. It contains information concerning the children conceived from licensed treatments from that date onward. Regarding heterologous fertilisation, the Human Fertilisation and Embryology Authority (Disclosure of Donor Information) Regulation 2004 removed the possibility of anonymous donation.

Personal data can be disclosed to the children born using this technique once they reach the age of eighteen from April 2005.

It is the right of a child to "to have a name , a nationality and" to know who are his parents, in the limits that it is possible, as was stated by the United Nations in The Convention on the Rights of the Child in 1989.[11]

The same rights are established in the European Charter of the Right of the Child 1992 SECTION 8.10:

> *"Every child shall be entitled to protection of his identity and, if appropriate, be allowed to know certain circumstances regarding his biological origin, subject to the restrictions imposed by national laws to protect the rights of third persons.*

11 The Convention on the Rights of the Child in 1989 http://www.unicef.it/Allegati/Convenzione_diritti_infanzia_1.pdf

Steps must be taken to lay down the conditions under which the child is to be given information regarding his biological origin and to protect the child from divulging of this information by third persons."[12]

Great Britain conformed to these provisions eliminating the complete anonymity in the donation.

The Authority also keeps a register of clinics' incidents. Clinic staff must report any adverse incident to the HFEA within 12 hours of the event if it is a serious incident, and within 24 hours in all others cases. Reporting adverse incidents is a statutory requirement but it is also done to avoid the possibility of errors and their causes from recurring. The focus on errors and incidents is necessary to the transparency of the clinics and helps raise staff awareness regarding care and practices used for future cases.[13]

The Authority has to issue directives in subjects of particular interest which require particular kind of attention: these are binding for the clinics involved however there are also other rules that the clinics need to follow. Some themes undertaken by the HFEA are Multiple Births; Import and Export of gametes and embryos and Collecting and recording of information.

For the licensed clinics the Authority provides Consent Forms: these forms are for the use of patients at the clinic and the record of their consent to the various aspects of fertility treatment, storage of ova, sperm and embryos. The consent form is necessary for the prediction of the Act 1990.[14]

12 European Charter of Right of the Child 1992, Resolution A3-0172/92

13 http://www.hfea.gov.uk

14 Schedule 3 Human Fertilisation and Embryology Act, 1990 A consent to the use of any embryo must specify one or more of the following purposes—
(a) use in providing treatment services to the person giving consent, or that person and another specified person together,
(b) use in providing treatment services to persons not including the person giving consent, or

An interesting case regarding the necessary consent or more specifically the lack of consent is *the Blood case* of 1997. In the UK the first step towards the practice of Assisted Reproduction Techniques is the compilation of the consent form. If there is something wrong or any doubts, a first appeal is made to the licensing committee. This is essentially a request for a hearing and in a second time an appeal can be made to the full HFEA. If the last appeal fails the Act forwards the appeal to the High Court. In almost all cases the position taken by the Authority prevails.

The Blood case is an example of a different end of the dispute and it took Mrs Blood years to reach a conclusion.

R v Human Fertilisation and Embryology Authority, Ex Parte Diane Blood began under these circumstances: Diane and Stephen Blood had been married for five years when Stephen died suddenly from meningitis. Just before life support equipment was removed, Diane asked the physicians to recover Stephen's sperm so that she could conceive his child. She claimed that the couple had been planning a child before Stephen's sudden illness.

(c) use for the purposes of any project of research,
and may specify conditions subject to which the embryo may be so used.
(2) A consent to the storage of any gametes or any embryo must—
(a) specify the maximum period of storage (if less than the statutory storage period), and
(b) state what is to be done with the gametes or embryo if the person who gave the consent dies or is unable because of incapacity to vary the terms of the consent or to revoke it,
and may specify conditions subject to which the gametes or embryo may remain in storage.
(3) A consent under this Schedule must provide for such other matters as the Authority may specify in directions.
(4) A consent under this Schedule may apply—
(a) to the use or storage of a particular embryo, or
(b) in the case of a person providing gametes, to the use or storage of any embryo whose creation may be brought about using those gametes,
and in the paragraph (b) case the terms of the consent may be varied, or the consent may be withdrawn, in accordance with this Schedule either generally or in relation to a particular embryo or particular embryos.

The hospital had an on-staff physician experienced in the technique of electro-ejaculation and the sperm was removed. HFEA was not consulted until the procedure was completed.

The HFEA later refused permission to allow the sperm to be used or stored because Stephen Blood had not given his written consent. Mrs Blood then petitioned to have the sperm exported to Belgium where the law allowed her to use the sperm, however the HFEA refused. In the ensuing litigation, the Court of Appeal ruled for the HFEA on the issue of written consent but for Mrs Blood on the issue of exportation concluding that the HFEA's refusal contravened UE law[15] guaranteeing freedom of movement for goods and medical services. Overall, the Court of Appeal agreed that the Authority could impose limits on the export of gametes from the UK, as long as they take into account a justification of Public interest being at the base of the ban. In the Blood case they ruled that this reflection was lacking and for this reason the decision of authority was changed with the judgement of the court. Mrs Blood went to Belgium some months later and gave birth to a son. Several years later she had a second son thanks to the same procedure. The Blood case stimulated a review of the law regarding consent for gamete removal. In circumstances where the patient is unconscious but likely to recover and treatment could cause sterility or when allowing such removal was deemed to be in the patient's best interest, removal was possible [16]

The legal battles of Mrs Blood weren't finished however, as after having sued to be allowed to use her deceased husband's sperm; she

15 Cityng the Court of Appeal: Corte di Giustizia UE, case 13.05.2003 n° 385

16 Ian Kennedy & Andrew Grubb, Medical Law 1306 (2000) [citing Sheila McLean, Review of the Common Law Provisions Relating to the Removal of Gametes and of the Consent Provisions in the Human Fertilisation and Embryology Act of 1990 (report to Ministers, July 1998)]

discovered that the children had a blank space on their birth certificates instead of their father's surname. (2003). The HFE Act did not allow use of the father's surname because the Human Fertilisation and Embryology Act 1990 declares that when a child is conceived using a dead man's sperm he is not to be treated as the father. This however was overruled when Mrs Blood took her case to the High Court. She ultimately prevailed in the High Court which found the Act incompatible with the European Convention on Human Rights which requires respect for a person's private and family life.
In this situation the law of the EU had a direct impact on the legal entitlements to health care of citizens of the European Union.

1. EVOLUTION IN REGULATIONS

The HFEA must be referred to regarding two primary sets of legislation: The Human Fertilisation and Embryology Act 1990 (as amended) and the Human Fertilisation and Embryology Act 2008.
The 2008 Act is primarily an amending legislation of provisions of the 1990 Act, which is the main framework governing the duties and responsibilities of the HFEA. The 2008 Act modified the 1990 original text of the Human Fertilisation and Embryology Act, in the provisions relating to legal parenthood and access to Assisted Reproduction Treatments.
One of the most important reforms introduced to the original text of the 1990 Act: it did not limit access to ART to couples only (woman-man) however in the interpretation of the original Act by medical staff, treatments could not be carried out on the woman without taking into consideration the best interests of the child, who, if born, would have need for a father. [17]

17 Human Fertilisation And Embryology Act 1990, Section 13

This behaviour which is extremely restricting for singles and lesbian couples was deleted from the 2008 Act. The Authority Code of Practice now gives a detailed explanation of what regulations the doctor must enforce when a person comes to ask about Medical Reproduction Techniques.

The point is to give to the future born good conditions of life with the parental support that every child deserves. This is done by verifying the absence in the person/s of alcohol or drug abuse, and of having committed offences against children.[18]

This supervision is not simple for a clinic which may not have the means and proper time necessary to dedicate to these investigations. There is however the possibility that a clinic can refuse to give clearance to access treatments. If this refusal comes from the National Health Service hospitals, the patient can ask for a judicial review, alternatively they can appeal to the Human Right Act under the European Convention of Human Right.[19]

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18 P. Passaglia con contributi di E. Bottini, C. Guerrero Picó, S. Pasetto e M. T. Rörig., La Fecondazione Eterologa. Available at: http://www.cortecostituzionale.it/documenti/convegni_seminari/CC_SS_fecondazione_eterologa_201406.pdf

19 In particular the articles of European Convention of Human Right to which the patients appeal are:

Article 8 – Right to respect for private and family life

1. Everyone has the right to respect for his private and family life, his home and his correspondence.
2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

Article 12 of the European Convention on Human Rights provides for the right to marry.

Men and women of marriageable age have the right to marry and to found a family, according to the national laws governing the exercise of this right

Article 14 a prohibition of discrimination

The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

In recent years there have been cases regarding prisoners demanding access to the Assisted Reproduction Technique in order to have children with their wives. The last important case was in December 2007, "*Dickson v. United Kingdom*". Kirk and Lorraine Dickson were born respectively in 1972 and 1958; in 1994 Kirk was convicted of murder (kicking a drunk to death) and sentenced to life imprisonment with a sentence of 15 years. His earliest expected release date was in 2009 and he had no children. In 1999 he met Lorraine by correspondence and in 2001 they married. Since they wished to have their own child, in October 2001 Kirk applied for facilities for artificial insemination and in 2002 Lorraine joined this application. In fact for their age it was unlikely that they would be able to have a child together without the use of artificial insemination techniques. In a letter dated 28 May 2003 the Secretary of State refused their application founding his refusal on the fact that their relationship, started in these particular circumstances, had yet to be tested in the normal environment of daily life. The fact was that any child who might be conceived would be without the presence of a father for an important part of his or her childhood. Kirk's conviction due to his violent crime however, would have been disregarded if he were allowed to father a child by artificial insemination.

The Dicksons asked for a judicial review which went before the Court of Appeal on 30 September 2004, but the decision was the same. Their application was unanimously rejected by the Court of Appeal. Auld LJ relied on principle in the Court of Appeal's ruling in the *Mellor case*.[20] In that case (taking into consideration the request of a prisoner for ART) the Court of Appeal (Lord Phillips) confirmed the reasons given to justify the restriction of artificial insemination facilities in exceptional circumstances. As to justification, he agreed

20 *R (Mellor) v Secretary of State for the Home Department* [2001] 3 WLR 533

with the Ministry policy that the deprivation of the right to conceive was part and parcel of imprisonment.

This statement did no more than restate the Policy, a "deliberate policy that the deprivation of liberty should ordinarily deprive the prisoner of the opportunity to beget children". In addition he considered that there would likely be serious and justifiable public concern if prisoners continued to have the opportunity to conceive children while in prison. Lord Phillips agreed that public perception was a legitimate element of penal policy.

As a last chance Kirk and Lorraine Dickson appealed to the European Court of Human Rights twice.

In 2007 in front of the Strasbourg Court sitting as a Grand Chamber, the couple's reasons prevailed. In their appeal the applicants complained about their denial to access artificial insemination facilities arguing that this breached their right to respect of private and family life guaranteed by Section 8 and the right to raise a family under Section 12 of the Convention of Human Rights.

The Chamber confirmed that persons continued to enjoy all Convention rights following conviction except the right to liberty; therefore any denial of prisoner's rights under Section 8 must be justified. In the Dickson's case public concern as justification for restriction of admission to the treatment of procreation was not permissible.

The reference to Section 12 of the Convention was not taken into account because the couple was already satisfied. This new sentence was supported by twelve votes to five (five dissenting opinions[21]).[22]

Following the judicial result of this case, other prisoners began to ask for admission to the Assisted Reproduction Techniques.

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21 dissenting opinion of judges wildhaber, zupančič, jungwiert, gyulumyan and myjer ;

22 http://www.bailii.org/eu/cases/ECHR/2007/1050.html

The 2008 Act also contains some key provisions according to the Ministry of Health: Firstly the recognition of same-sex couples who are not married/neither civil partners, as legal parents of children conceived through the use of donated sperm, eggs or embryos. These provisions enable for example, the civil partner of a woman who carries a child with IVF to be recognized as the child's legal parent by a parental order. This is a Court order to regulate the parentage position for intended parents under English law; however the restriction is that one of the petitioners must be genetically related to the child to apply for a parental order. [23]

Other relevant provisions concern banning sex selection of offspring for non-medical reasons and the possibility to ensure regulation of "human-admixed" embryos that are created from a combination of human and animal genetic material for research.

These embryos are created for research purposes to obtain stem cells and to assist the understanding of disease processes. Even in a liberal country such as the UK, the idea to create chimeric-embryos is something that can have an impact on the public opinion. That is why recognizing the difficult issue of creating human-admixed embryos, even if only for research, the HFEA decided in 2007 that a public consultation should be held on the social implication of creating these embryos.[24]

In September 2007 the Authority, after taking into consideration the results of the consultation, agreed on a policy for the licensing of cytoplasmic hybrid research. Today the studies on human-admixed embryos are illegal except which that are licensed by the Authority. However growth of human-animal hybrids cannot exceed 14-days, the legal limit research on human embryos. It is also illegal to

23 https://www.gov.uk/become-a-childs-legal-parent

24 the consultation document can be consulted at: http://www.hfea.gov.uk/docs/Hybrids_Chimera_review.pdf

transfer any human–animal hybrid into either a human or animal womb.[25]

Lastly in this discussion regarding Artificial Reproduction Techniques I would like to consider the position of those against ART, namely those people who object on the basis of the right to conscientious objection. It is the right of medical and nursing staff in clinics performing these types of treatments, to not actively participate in the treatments for reasons of personal conscience.

Doctors and Nurses who object can appeal under Section 38 of the Human Fertilisation and Embryology Act 1990 which declares:

> *(1)No person who has a conscientious objection to participating in any activity governed by this Act shall be under any duty, however arising, to do so.*
>
> *(2)In any legal proceedings the burden of proof of conscientious objection shall rest on the person claiming to rely on it.*
>
> *(3)In any proceedings before a court in Scotland, a statement on oath by any person to the effect that he has a conscientious objection to participating in a particular activity governed by this Act shall be sufficient evidence of that fact for the purpose of discharging the burden of proof imposed by subsection (2) above.*

The position of nurses and midwives who have a conscientious objection to assisting during technical procedures required to conceive a baby is also covered under Section 38(2) of the Human and Fertilisation and Embryology Act 2008.[26]

25 http://www.hfea.gov.uk/519.html

26 http://www.nmc-uk.org/Nurses-and-midwives/Regulation-in-practice/Regulation-in-Practice-Topics

When refusing to not perform or assist in these activities the conscientious objectors must be sure that they abide by the anti-discrimination provisions included in the Human Rights Act 1998.

2. THE HETEROLOGOUS FERTILISATION

The definition of In Vitro Fertilisation has already been given as well as that of other techniques accepted as artificial reproduction techniques under United Kingdom law.

When we hold about Heterologous Fertilisation, we refer to these procedures but involving sperm and oocyte from donors.

The UK is very open-minded and often observes experiences of other European countries in Assisted Reproduction, in particular regarding the use of donors' gametes. In England the donation of sperm and oocytes fertilized and unfertilized is allowed.

Although donation of semen for artificial insemination does not generally raise any problems, in several countries we can find restrictive legislation. In Austria the federal law on assisted reproduction (1992) allows recourse to the seed of a third only in exceptional cases.

Whilst in Switzerland the ethical guidelines on assisted reproduction and health in the federal regulation bill concerning IVF only allows married couples to benefit from the donation of sperm from a third party (n. 3.2, Art. 3.3)[27].

27 http://www.treccani.it/enciclopedia/la-fecondazione-assistita-una-sintesi-comparativa_(Frontiere-della-Vita)

With the donation of female gametes we find more difficulties in European countries such as in the more liberal countries like Norway which only allow in vitro fertilization with eggs and semen belonging to the same couple.

The Human Fertilisation and Embryology Act of 1990 admitted heterologous fertilisation, because here the law focus its attention not on pre-established criteria, but on providing for the welfare of the child born from the treatment.

In England the access to Assisted Reproduction Techniques both homologous and heterologous is permitted to married couples[28] or civil partners[29], as well as singles (women and man).[30]

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28 Human Fertilisation and Embryology Act, 2008, section 49:
Meaning of references to parties to a marriage
(1) The references in sections 35 to 47 to the parties to a marriage at any time there referred to—
(a) are to the parties to a marriage subsisting at that time, unless a judicial separation was then in force, but
(b) include the parties to a void marriage if either or both of them reasonably believed at that time that the marriage was valid; and for the purposes of those sections it is to be presumed, unless the contrary is shown, that one of them reasonably believed at that time that the marriage was valid.
(2) In subsection (1) (a) "judicial separation" includes a legal separation obtained in a country outside the British Islands and recognized in the United Kingdom.

29 Human Fertilisation and Embryology Act 2008, section 50:
Meaning of references to parties to a civil partnership
(1) The references in sections 35 to 47 to the parties to a civil partnership at any time there referred to—
(a) are to the parties to a civil partnership subsisting at that time, unless a separation order was then in force, but
(b) include the parties to a void civil partnership if either or both of them reasonably believed at that time that the civil partnership was valid; and for the purposes of those sections it is to be presumed, unless the contrary is shown, that one of them reasonably believed at that time that the civil partnership was valid.
(2) The reference in section 48(6) (b) to a civil partnership includes a reference to a void civil partnership if either or both of the parties reasonably believed at the time when they registered as civil partners of each other that the civil partnership was valid; and for this purpose it is to be presumed, unless the contrary is shown, that one of them reasonably believed at that time that the civil partnership was valid.

30 Human Fertilisation and Embryology Act 1990, section 27:
Meaning of "mother"; section 28: Meaning of "father" and amendments from Human Fertilisation and Embryology Act 2008, Sections 33 to 47

There are no legislative restrictions on the age a women is eligible to receive IVF treatment. The National Health System, which is the social publicly-funded health care system in the UK that provides health care to anyone normally residing in the UK, issues recommendations that might pragmatically limit the availability of treatment for women aged 40/45 years or older.

The problem that the British policy faced with the practice of heterologous fertilisation was the parenthood relationship, because genetically the baby born was not in a blood relationship with one or sometimes both parents. The 2008 Act revised this particular situation, modifying the laws about affiliation. These rules entered into force in April 2009.

The provisions previously referring to married couples now also refer to gay couples. This is due to the same-sex marriage legislation being passed by the Parliament in July 2013 and coming into force on 13 March 2014 in England and Wales.[31]

There are some differences however between the application of the common law provisions and this Bill, in particular when we take into account the matter of parenthood.

In fact the common law "presumption of legitimacy" that a child born to a woman during her marriage is also the child of her husband is not extended by Clause 11 to the same-sex married couple. The explanatory notes by Parliament refer to the case when two women are married to each other and one of them has a baby, her wife is not the presumed other parent of the child. There are derogations in common law for the other woman in the marriage who does not give birth to become the legal parent of the baby: for example, in section 42 of the Human Fertilisation and Embryology Act 2008 as amended by paragraph 36 of Schedule 7 of the Marriage (same sex) Act.

31 Look at Parliament's explanatory note to bill , Clause 11, http://www.publications.parliament.uk/pa/bills/cbill/2012-2013/0126/en/2013126en.htm

The provisions concerning Adoption are amended by the 2013 Marriage Act: the Adoption and Children Act 2002 provides for the meaning of "a couple" for the purposes of that Act:

> "*In this Act, a couple means-*
> *(a) a married couple, or*
> *(aa) two people who are civil partners of each other, or*
> *(b) two people (whether of different sexes or the same sex) living as partners in an enduring family relationship.*" [32]

2.1 DONATION AND DONOR ANONYMITY

In the UK, a donation using the Artificial Reproduction Techniques includes eggs, sperms and embryos.

The donations have to be made in clinics licensed with the HFEA and these clinics and all the information about their donors are held by the National Gamete Donation Trust, a government-funded charity. The Trust aims to raise awareness and seek ways to alleviate the national shortage of gamete (sperm, egg and embryo) donors.

The gametes can be donated to help infertile people to have children of their own (around 2,000 children are born every year in the UK using donated eggs, sperm or embryos[33]), but can also be used for research purposes.[34]

Making a donation in a licensed clinic puts both donor and receiver in a safe medical position because gametes donated through a clinic must be screened for various medical conditions. Sperm and embryos

32 http://www.publications.parliament.uk/pa/bills/cbill/2012-2013/0126/en/2013126en.htm

33 http://www.hfea.gov.uk/egg-and-sperm-donation.html

34 The HFEA have only issued one clinic a license to research on donated eggs to create embryos. This was granted to the Newcastle Fertility Centre at Life.

are also quarantined for six months. This helps ensure that babies born from donations are healthy and there are no risks for the women who receive them. The importance to use HFEA recommended clinics is widely promoted because in England and other countries there are many websites which eluding the law, contact women who wish to conceive a baby with voluntary sperm donors, with no legal or medical supervision. Using this kind of donation can put the woman's health and that of the unborn child in danger because of the lack of medical supervision. Other issues may arise regarding the donor and his eventual claim to rights over the baby to be born as he is considered to be the legal father, and if this man is not a registered donor, the child may never know the identity of his biological parent.

2.1.1 REQUIREMENT TO DONATE

In order to become a donor people need to fulfil certain criteria. These criteria are established to minimize the risk of transmitting infections to the women receiving the donation, or genetic diseases or malformations to any children born.

It is a legal requirement for the donors to consent in writing before donating. The consent can be changed or withdrawn at any time up to the point at which the gametes are used in treatment.[35]

To become a sperm donor there is an age limit which the HFEA modified in 2012. The Authority reduced the legal age at which a man can continue to donate his sperm from 45 to 41 years. The reason was to avoid the transmittal of genetic abnormalities, a risk which increases when the men who donate are over 40 years of age.

The sperm donor must submit to a screening test in order to verify that he is free of serious medical disabilities and has no family history of inherited disorders. He also makes a commitment to keep

35 http://www.hfea.gov.uk/egg-and-sperm-donors.html

in touch with the clinic a few times a week, over a period of several months.

The number of children that can be born from using a donor sperm is regulated by law, therefore a centre would not accept any man as a donor, if he has previously donated in another clinic.

The age limit to become an egg donor is between 18 and 35 years old. Women need to be free of any serious medical problems or disabilities and have no history of congenital, family or hereditary disease. As with the sperm donors, they must undergo medical tests to verify their health status. It is interesting to note that even a sterile woman can donate her gametes, if she still has her ovaries.[36]

For women some clinics offer "egg-sharing" programs. Women undertaking fertility treatments may produce surplus eggs and share these with other women unable to produce them, so both parties have a chance at becoming pregnant.[37] Clinics may allow women who are eligible to become egg sharers the advantage of using this as a way to subsidise or be provided with free IVF treatment.

The Authority decided that a donor can create up to 10 families with their donations to avoid the risk of consanguineous relationships between offspring and related welfare problems. There is no limit to the number of cycles they can participate in and no limit to the number of children created within those 10 family units.[38]

In the end the criteria for embryo donation is the same, taking into account the individual gametes (egg and sperm) of the donors. In exceptional circumstances a clinic may accept donors outside the age

36 http://www.ngdt.co.uk

37 IVF treatment begins with stimulation of the ovaries to produce eggs. Generally, the result is the production of between 10-12 eggs, but UK law allows only one or two embryos to be transferred to the uterus. Remaining embryos can be frozen, but in most cases not all are used. Citing : http://www.eggsharing.com

38 14 July 2011 Human Fertilisation and Embryology Authority decision in donation policies. Finding at :http://www.ngdt.co.uk

bracket if the numbers of embryo donations are smaller than that of gametes donations.[39]

Embryos are usually donated by couples who have successfully had their baby from IVF and want to help other couples.

A case that has provoked much discussion regarding the conservation and use of embryos is the *"Evans v. United Kingdom"*[40]. Here the case did not take into account the donation of the embryo, but the importance of the consensus to use this embryo. Consensus that, as we have said, must be present both at the time of the donation and at the moment of use of the techniques of artificial reproduction.

In October 2001 Natallie Evans and Howard Johnston got engaged. During an appointment at a fertility treatment clinic they were encouraged by the clinic to undergo IVF treatment prior to surgical removal of Ms Evans ovaries as she had been diagnosed with a pre-cancerous condition of the ovaries. As a result of the treatments six embryos were created and frozen from the gametes of both partners, Natallie and Howard. In accordance with the rules established in the 1990 Act, prior to the creation and storage Evans and her partner signed off on their consent and were informed that it would be possible for either of them to withdraw this consent at any time before the embryos were implanted in the woman's uterus.

On 26 November 2001, Miss Evans underwent an operation to remove her ovaries, so the frozen embryos were the only chance for her to conceive her own children. After the operation she was told she would need to wait for two years before the implantation of the embryos in her uterus. Unfortunately the relationship between Mr Johnston and Miss Evans ended in 2002 and a few months later he wrote to the clinic storing the embryos, asking that they be destroyed.

39 Births following donor conception treatment, statistic make by HFEA, viewable at: http://www.hfea.gov.uk/donor-conception-births.html

40 European Court of Human Right sitting as a Grand Chamber; case *Evans v. United Kingdom*; application no. 6339/05, 10 April 2007

When the clinic informed Miss Evans of this request, because the Authority established that both parties have to be informed before embryos are destroyed, she began legal proceedings in the High Court and in 2004 at the Court of Appeal. The British judges however ruled in favour of Mr Johnston.[41]

The High Court's sentence[42] was based on the change of circumstances that occurred after he had given his consent, in accordance with the Human Fertilisation and Embryology Act of 1990, schedule 3.[43] It also cited that there was no violation of rights to apply to this situation as all patients undergoing IVF treatment, irrespective of their sex, should be treated the same:

> *"If a man has testicular cancer and his sperm, preserved prior to radical surgery which renders him permanently infertile, is used to create embryos with his partner; and if the couple have separated before the embryos are transferred into the woman, nobody would suggest that she could not withdraw her consent to treatment and refuse to have the embryos transferred into her. The statutory provisions, like Convention rights, apply to men and women equally."*

In the decision of the Court of Appeal[44] we can find almost the same premise on which Miss Evan's request was rejected. Here the judges made a comparison between the fertile and infertile woman, but did not all agree as to what was the right comparison to refer to: for Lords Justices Thorpe and Sedley the comparison was "*between*

41 In 2003 the High Court of Justice; the refusal is confirmed in June 2004 by the Court of Appeal and in November of the same year; the Law Lords prevents Natallie arriving at the House of Lords

42 E*vans v. Amicus Healthcare Ltd and Others* [2003] EWHC 2161 (Fam)

43 http://www.legislation.gov.uk/ukpga/1990/37/schedule/3

44 *Evans v. Amicus Healthcare Ltd* [2004] EWCA Cit 727

women seeking IVF treatment whose partners had withdrawn consent and those whose partners had not done so"; and for Lady Justice Arden the comparison was between "*fertile and infertile women, since the genetic father had the possibility of withdrawing consent to IVF at a later stage than in ordinary sexual intercourse"*.
The judges agreed that which ever interpretation was decided upon, the difference in treatment was justified and proportionate under Article 14 of the Convention for the same reasons that underline the finding of no violation of Article 8. In addition they did not find the embryos were not entitled to protection under Article 2, since under domestic law an embryo is not recognized as having any rights up to the moment of birth.
The Court knew this was the last chance for Natallie to have her own baby, however they retained she could use an egg or other embryo donation to conceive a baby, even if it would not be genetically related to her.
As a last chance, Miss Evans brought her case in front of the European Court of Human Rights, claiming a violation of rights 2, 8, 14 of the Convention for the Protection of Human Rights and Fundamental Freedoms.[45] The European Court of Human Rights, sitting as a Grand Chamber deliberated in March 2007.
The only thing that Miss Evans achieved initially was the preservation of the embryos until the court had completed its examination of the case under rule 39 of The Rules of Court.[46]

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45 http://conventions.coe.int/Treaty/en/Treaties/Html/005.htm

46 **Article 39 – Interim measures**
"1. The Chamber or, where appropriate, its President may, at the request of a party or of any other person concerned, or of its own motion, indicate to the parties any interim measure which it considers should be adopted in the interests of the parties or of the proper conduct of the proceedings before it.
2. Where it is considered appropriate, immediate notice of the measure adopted in a particular case may be given to the Committee of Ministers.
3. The Chamber may request information from the parties on any matter connected with the implementation of any interim measure it has indicated."

Miss Evans also appealed to a violation of the Right of Life according to Article 2:

> *1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.*
> *2. Deprivation of life shall not be regarded as inflicted in contravention of this article when it results from the use of force which is no more than absolutely necessary:*
> a. *in defence of any person from unlawful violence;*
> b. *in order to effect a lawful arrest or to prevent the escape of a person lawfully detained;*
> c. *in action lawfully taken for the purpose of quelling a riot or insurrection.*

Taking into consideration Article 2 could mean that the embryo has the right to life as a human being. In fact the Court recalled that the issue of when the right to life began comes within the margin of appreciation of the State concerned. Under English law an embryo does not have independent rights and could not claim a right to life under Article 2, so there was not a violation of this article.

> *Article 8 – Right to respect for private and family life*
> 1. *Everyone has the right to respect for his private and family life, his home and his correspondence.*
> 1. *There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or*

crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

In this case the problem was to find a balance between the right for privacy of Mr Johnston and the right to create a family, which involved both of them. Natalie desire to become a mother of her own babies and Mr Johnston right to not have a family with Miss Evans. The Grand Chamber agreed that Article 8 was applicable in this case because the "right of a private life" includes the right to respect for both parties in the decision to become or not become a parent. The question is:

"Whether there exists a positive obligation on the State to ensure that a woman who has embarked on treatment for the specific purpose of giving birth to a genetically related child should be permitted to proceed to implantation of the embryo not with standing the withdrawal of consent by her former partner, the male gamete provider"

Once there was no European law regulating IVF treatments and consent for the use of embryos, the Court had to refer to the Human Fertilisation and Embryology Act of 1990. The Court found in the UK Act a very detailed legislation which effectively balanced competing public and private interests. Taking into account the sections regarding embryos, Schedule 3 of 1990 Act: the Court referred to the storage of embryos for a period of no more than ten years and the legal standing to not continue storage if the woman was passed the age limit to be subjected to the treatment. Upon completion of the provision, there was reference to the necessary written consent for each gamete provider: paragraph 4 of Schedule 3 provides that:

> *"the terms of any consent under this Schedule may from time to time be varied, and the consent may be withdrawn, by notice given by the person who gave the consent to the person keeping the gametes or embryo ..."* up until the point that the embryo has been implanted in the uterus.

Miss Evans here submitted that it was neither necessary nor in proportion to the situation to give such power to a single gamete provider. The Court, making a comparison with other European countries, underlined that the UK was not the only country to grant both parties of IVF treatment the right to withdraw consent for the use or storage of their gametes at any stage up to the moment of embryo implantation. The United Kingdom did not exceed the margin of appreciation afforded to it or upset the fair balance required under Article 8, so there was no reason to find a violation of the rights under this Article.

> *Article 14 – Prohibition of discrimination*
> *The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.*

Miss Evans complained of discrimination contrary to Article 14 in conjunction with Article 8. She complained about unequal treatment of herself and any other women in the same position subjected to treatment of assisted reproduction. For the Grand Chamber the reasons given for finding that there was no violation of Article 8 also afforded a reasonable and objective justification under Article 14.

Once again there was no violation of any Conventions.[47]
This decision which provoked much discussion had a big impact on fertility laws in the UK and other countries.

2.1.2 COMPENSATION

The HFEA in the Code of Practice has underlined a guide for compensation to be given to donors. These new limits were introduced in April 2012, as a result of a public consultation made in 2011.[48] Clinics are now able to offer donors compensation which better reflect their expenses. For sperm and embryo donors the limit is a fixed sum of £35 per clinic visit including expenses, and for egg donors the limit is a fixed sum of £750 per cycle of donation, including expenses. Other form of donation under payment is illegal in the UK. England's clinics cannot bring in donors from other countries, however they can import eggs and sperm from abroad[49], in this case the donors whose sperm or eggs are imported in the UK had the same compensation as they could be UK donors.
Looking at other European countries we can see that almost all laws regarding this theme are the same. The only difference is that in some countries, the donors compensation is higher than in England (for example in Cyprus the compensation payment is highest and donation costs are very low compared to the UK[50]).

47 For the no violation of the Articles 8; 14 the judges votes were thirteen to four. The dissenting judges were: TÜRMEN, TSATSA-NIKOLOVSKA, SPIELMANN AND ZIEMELE

48 See http://www.hfea.gov.uk/5605.html

49 Currently about 20% of sperm donors and 2% of egg donors are from overseas, compared to 12% and 4%, respectively, in 2005. Data of 2013 from "Donating sperm and eggs. Have your say..." Text sourced from: www.hfea.gov.uk/donationreview

50 http://www.fertilityclinicsabroad.com/ivf-cyprus.html

In the European Union an open commercial trade in gametes or embryos is apparently not openly permitted. Member states are enjoined by the EU Tissues and Cells Directive to see that these are donated voluntarily, and money cannot change hands unless payments are *"strictly limited to making good the expenses and inconveniences of donation"*.[51]

2.1.3 REMOVAL OF ANONYMITY

For the first time in 2004 the Human Fertilisation and Embryology Authority took into account the topic of the anonymous donation and decided that as a result of the growing use of ART, it was important to let the children conceived by these methods know something about their genetic origin. For this purpose the HFEA issued the Human Fertilisation and Embryology Authority (Disclosure of Donor Information) Regulation 2004.[52] The new regulation came into force on 1 April 2005. The donors of sperm, eggs or embryos after this date are by law, identifiable.

Any person born as a result of a donation after this time is entitled to request and receive their donor's name and last known address, once they reach the age of 18.

This new regulation is not retrospective, so those who donated before 1 April are protected by anonymity. If the conceived child asks something about his gamete's donor, the HFEA is not allowed to reveal any identifying information.

It is important to know that the donor has no legal right to contact the babies who are born as a result of his/her donation. That right and decision belongs only to the child. The reason is obviously understandable, some children are not aware they have been

51 EC Directive 2004/23/EC of 31 March 2004

52 Available at: http://www.legislation.gov.uk/uksi/2004/1511/regulation/1/made

conceived from a donation and if contact is allowed from either of the donors, the legal parent who may have chosen anonymity would be find out.

A donor who has donated before that date wanted to be known, it is possible. The HFEA gives the opportunity for removal of anonymity; however the donor must request the HFEA to re-register them as an identifiable donor.

A second intervention to regulate the donation of embryos and gametes can be found in the Human Fertilisation and Embryology Act 2008, Section 24.[53]

Firstly this contains a reduction of the age at which donors can request information about donor and genetic parentage : at the age of 16 years the donor-conceived child can seek information about the number, sex and year of birth of their 'half-siblings' conceived using gametes of the same donor but not information regarding the 'donor's legal children'. The donor-conceived child can also seek information as to whether or not they are genetically related to someone they intend to marry, enter a civil partnership or have intimate physical relationship with. Before 18 years of age "*regulations cannot require the Authority to give the applicant any information which identifies the donor*". Following the removal of donor anonymity in April 2005, there is an interested provisions of point 6, section 31ZA regarding "Request for information as to genetic parentage etc. "of Section 24. This states that the HFEA has the power but is not obliged to inform donors that identifying information has been applied for, however they cannot disclose the identity of the person seeking it.

Since removal of anonymity the UK has seen a reduction in donations (in particular egg donations had an immediate and steep fall in the number of donors, whilst men registering as sperm donors

53 http://www.legislation.gov.uk/ukpga/2008/22/section/24

rose by 6% in the year following this law) as can be seen in the HFEA statistics.[54] Several studies regarding potential new identifiable donors explain some of the reasons as to why they may or may not donate their gametes: emotional liability was cited nearly as much (8.4%) as financial liability (10.8%). The spectre of the offspring "knocking on the door 18 years later" and the impact of any contact on the donor's family was frequently mentioned, being able to identify the gamete donor obviously allows this possibility and some gave this as a reason for not donating. Donors themselves suggested a possible solution for these problems could be to set up support systems to oversee contact between donors and donor offspring and to provide general ongoing support.

Likewise the British Fertility Society in its response to the HFEA's consultation on donor-assisted conception has also highlighted the need to provide support for those donating non-anonymously.

In 1988 to help infertile people and couples who were considering fertility treatments, the British Government established the British Infertility Counselling Association (BICA). This is the only professional association for infertility counsellors and counselling in the UK.[55]

There is no similar body for the other participants of ART, namely the donors. To fill this void the government commissioned the BICA to undertake some preliminary work on the provision of counselling services for donors and conceived children in circumstances such as when they request information about their genetic origins from the HFEA Register of Information. Unfortunately these recommendations were not acted upon. The reason could have been that the children conceived would not be requesting information about their non-anonymous donors until 2023, therefore it was not an

54 http://www.hfea.gov.uk/donor-conception-treatments.html

55 http://www.bica.net/

immediate problem to be resolved and any small issue in this highly sensitive area could frighten potential donors from donating their gametes.[56] The British Fertility Society in 2005 did provided a solution for increasing the number of donations through a donor recruitment campaign:

> *"Plan for counselling and support service in place for future enquiries, including services around times of information sharing and/or contact with donor-conceived offspring"*[57]

The most recent recruitment campaigns unfortunately have not followed these guidelines, preferring to focus on the emotional aspect of the donation. For example the London sperm bank in March 2010, decided to focus on recruiting altruistic, emotionally mature men who wanted to do something kind to help others. Other publicity has used the power of the media: journalists often contact the National Gamete Donation Trust to speak to donors to see if they would like to tell their stories. The Trust created a special page on its website dedicated to the media request to facilitate these contacts.[58] This narration using the media keeps donations in the public eye and over time have helped recruit more donors.

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56 Lucy Frith, Eric Blyth and Abigail Farrand, UK gamete donors' reflections on the removal of anonymity: implications for recruitment. From Human Reproduction Vol.22, No.6 pp.1675-1680, 2007. Available at: http://humrep.oxfordjournals.org

57 British Fertility Society response to the Human Fertilisation and Embryology Authority public consultation on The Regulation of Donor-Assisted Conception, February 2005. Available at: http://www.fertility.org.uk/practicepolicy/index.html

58 http://www.ngdt.co.uk/media-request

2.2 THE QUESTION OF PATERNITY AND MATERNITY

The Human Fertilisation and Embryology Act 2008 defines who are the legal parents of the child born after a fertility treatment under English law. Concerning same-sex married couples and civil partners there are no differences in the law applied to either of them. Following amendments to the 1990 Act, of September 2009 both parties of these couples can be the legal parents of the children born as a result of artificial insemination.

The woman who conceives the baby is always the mother.[59] The genetic link with the child however is not recognized but rather the gestational link, this is what is called "Gestational Surrogacy"[60]. There are other ways under English law for another woman to become the legal parent, but generally this is the provision.

The degree of legal relationship with the other parent, male or female, it depends on the way in which insemination occurred.[61]

As we have seen for private insemination with a "Do It Yourself" technique, there are not UK laws against it. However when a woman decides to apply this type of insemination, the parenthood link to the conceived baby must be taken into consideration.

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59 Human Fertilisation and Embryology Act 2008; Section 33:
Meaning of "mother"
(1) The woman who is carrying or has carried a child as a result of the placing in her of an embryo or of sperm and eggs, and no other woman, is to be treated as the mother of the child.
(2) Subsection (1) does not apply to any child to the extent that the child is treated by virtue of adoption as not being the woman's child.
(3) Subsection (1) applies whether the woman was in the United Kingdom or elsewhere at the time of the placing in her of the embryo or the sperm and eggs.

60 The gestational surrogacy, the pregnancy results from the transfer of an embryo created by in vitro fertilisation (IVF), in a manner so the resulting child is genetically unrelated to the surrogate. From: http://en.wikipedia.org/wiki/Surrogacy

61 http://www.hfea.gov.uk/399.html?fldSearchFor=paternity

The legal paternity depends on whether the relationship between the mother and her partner falls under the provisions of Section 35[62] or Section 42[63] (for the same sex couples) of the 2008 Act. If it is under one of these rules the mother's husband or civil partner (if it is a woman) will be the child's legal father or second parent and the biological father has no legal connection with the child. For same-sex couples the insemination must have been after April 2009. If it took place before then the old law applies and the sperm donor is recognized as the legal father.

When the relationship is not protected by the Act the donor is the legal father of the conceived child and the mother's partner has no legal relationship with the baby born, it can only be created through an adoption or parental order. Both require a formal court order. The biological father in these cases would cease to be the legal parent because under UK law, a child can only have two parents.

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62 Human Fetilisation And Embryology Act 2008, Section 35:
Woman married at time of treatment
(1) If—
(a) at the time of the placing in her of the embryo or of the sperm and eggs or of her artificial insemination, W was a party to a marriage, and
(b) the creation of the embryo carried by her was not brought about with the sperm of the other party to the marriage,

then, subject to section 38(2) to (4), the other party to the marriage is to be treated as the father of the child unless it is shown that he did not consent to the placing in her of the embryo or the sperm and eggs or to her artificial insemination (as the case may be).
(2) This section applies whether W was in the United Kingdom or elsewhere at the time mentioned in subsection (1)(a).

63 Human Fetilisation And Embryology Act 2008, Section 42:
Woman in civil partnership at time of treatment
(1) If at the time of the placing in her of the embryo or the sperm and eggs or of her artificial insemination, W was a party to a civil partnership, then subject to section 45(2) to (4), the other party to the civil partnership is to be treated as a parent of the child unless it is shown that she did not consent to the placing in W of the embryo or the sperm and eggs or to her artificial insemination (as the case may be).
(2) This section applies whether W was in the United Kingdom or elsewhere at the time mentioned in subsection (1).

If conception occurs after treatment in a UK licensed clinic, other rules apply. The centre should provide information to people seeking treatment about legal parenthood or should direct those people to suitable sources of information. This information should include who will be the child's legal parents under the HFE Act 2008 and other relevant legislation.

The partner of the legal mother who agreed to the treatment is considered to be the parent of the baby, be they male or female. If they are married or in a civil partnership, he/she will automatically become the second parent of the baby but not his father or mother. If they are not married or in a civil partnership, he or she, will only be recognized as a donor, unless the two participating parties have given their prior written consent. Any other circumstances must be formalised by the Court. The different title of "other parent" is the only difference because the parenthood legal duties are the same as those of the father or mother. The most important thing is to agree on the consent form to the procedure. When a couple, married or not goes to a registered clinic to undergo IVF treatment involving a donor, both parties must fill out the consent form. On the form the mother must declare the name of the partner that she wants to be the legal parent of the conceived child. In this situation with the continued persistence of consent until the end of treatment, the partner of the woman will be the legal father of every child born as a result of said treatment. Of course a single woman can choose to undergo treatment alone and in this case, there will be no legal father (unless the donor expresses the desire to also become the legal father) of the child registered on the birth certificate. The same situation occurs when the civil partner or the husband of the mother does not agree with the procedure. In these circumstances, the burden of proof is in the hands of the husband of the couple, there is the

legal presumption that children born in wedlock are those of the husband and therefore he is their father.[64]

It is interesting to see that the law does not say anything about the *relationship* between the two people who want to undergo the procedure of artificial insemination. The only limit is that they are not linked by a bond of kinship. They can just be two friends with a desire to have a baby. The law favours married couples and civil partners, as already seen. Furthermore, under the law, fertilisation by husbands or civil partners through use of their gametes after their death, allows them to become parents of any child born thereafter.[65]

2.2.1 THE PARTICULAR CASE OF TRANSEXUAL PARENTHOOD

Artificial reproduction techniques can also help the transgender who has the desire to have a baby, by giving them the possibility to store eggs or sperm for future use before the change of sex.

They must store eggs or sperm in anticipation of hormone therapy or surgery that will render them 'prematurely infertile'. In this particular case it is also possible to extend the storage period from ten years up to a maximum of 55 years.

The provision which ensures in some way parenthood of transgender's children is covered under Section 12 of the Gender Recognition Act 2004[66] which states:

64 It is a common law presumption. From Cristine Rossini, English As a Legal Language

65 Human Fertilisation and Embryology Act 2008, Section 40

66 Available at: http://www.legislation.gov.uk/ukpga/2004/7/contents

> *The fact that a person's gender has become the acquired gender under this Act does not affect the status of the person as the mother or father of a child.*

If they have children before they legally change gender, this provision protects the existing legal parenthood. Therefore they can remain the legal father or mother of the children just as they were, before the change of sex. There is no clear provision for transgender parents who conceive after having transitioned and the Human Fertilisation and Embryology Act does not say anything in this particular case. It is possible to apply Section 12 of the Gender Recognition Act also to these cases, but the problem remains that if the genders use their own gametes for treatment, because of the change of the sex, it is possible that they could be simply considered as a donor. Under Section 12, for example, a man, who has become a woman but used his sperm to conceive with his partner, if married or in a civil partnership, would only be classified the second legal parent of the baby but not his father. Transexual parents wish to claim parenthood status that they have under their previous gender, as a mother if they had become a man and as a father if they had become a woman. The issue of parental bond for those who conceive after a gender transition has not yet been legally tried in any UK court to date.

2.3 THE CLINICS PAY ATTENTION BUT SOMETIMES MISTAKES HAPPEN

A licensed clinic must clearly state the safe, legal and medical practices to any party that applies to them, sometimes however the clinics do commit mistakes.

To decrease the number of these errors the HFEA has begun monitoring the clinics and publishes reports on adverse incidents in fertility clinics. The latest figures are from 8 July 2014, where the Authority reported:

- The overall number of incidents reported remains steady
- Only three serious 'grade A' incidents were reported in three years
- Avoidable 'grade C' incidents remained too high, incidents reported[67]

The Authority in the Report classified the clinic incidents in three categories, depending on the degree of seriousness. Grade A incidents were regarded as the most serious and Grade C the least. There were also two other areas: 'near misses' and 'not incidents'. These were not considered real incidents but unplanned events that did not result in injury, illness, or damage and events that did not fall within the HFEA's definition of incidents. However incidents that caused loss or damage to the patient, gamete and embryos or clinic staff.

The real grades of clinic incidents are A, B, and C:

- Grade A incidents, for example where a patient is implanted with someone else's embryo are investigated immediately upon being reported. The process includes an on-site inspection and a report is passed onto the HFEA's Licence Committee.
- Grade B incidents are where all of a patient's embryos are lost. These incidents are investigated by the clinic and then reported to the HFEA within 10 working days after which the

67 http://www.hfea.gov.uk/9017.html

inspection team decides, based on the facts, whether an inspection is required.

- Grade C incidents where one of a patient's eggs may be rendered unusable but others remain, making her opportunity for treatment still viable, are investigated by the clinic. A report must be produced by the clinic, to the HFEA although not necessarily submitted for assessment.[68]

The Number of incidents reported to the HFEA between 1 January 2010 and 31 December 2012

The figure realized from data of *"Adverse incidents in fertility clinics: lessons to learn 2010-2012"*[69], contains the result of how many incidents were reported to HFEA and how severe they were. About 60,000 cycles of fertility treatment are carried out in the UK annually[70], this suggests that an estimated 1% of cycles are affected by some sort of adverse incident. As we can see just three cases of Grade A incidents were found which were the removal of frozen sperm from storage within its consent period, the contamination of 11 patient cellular debris that may have contained sperm, and in 2012 regard a family seeking to have treatment with donor sperm in order to have a genetically related sibling were instead given sperm from a different donor so they had two genetic fathers to their sibling.
A similar case of interest from a juridical point of view occurred in another situation of a Grade A incident: the *A (A Minor) & Ors v A*

68 http://www.hfea.gov.uk/9017.html

69 Available at: http://www.hfea.gov.uk/docs/Adverse_incidents_in_fertility_clinics_2010-2012_-_lessons_to_learn.pdf

70 Report of HFEA; Fertility Treatments in 2011: Trends and Figures

Health & Social Services Trust [2010] NIQB 108[71]. In this noteworthy case the circumstances of the court case were very different from all precedents. Here in fact the applicants were the minors, the children conceived under the treatment. It was not a case of civil liability against the clinic on behalf of the parents caused by an adverse clinical incident, that liability had already been recognized by the medical centre to parents. In this case the centre refused to recognize responsibility toward the minors.

The plaintiffs, A and B, are the children born as a result of IVF treatment provided by the clinic to the plaintiffs' mother.

What is the problem in the procedure? The parent of the applicants had explicitly asked the medical centre that assisted fertilization happen with gametes that allowed future children to have their same skin colour "Caucasian" or white. In fact following normal practice the mothers' eggs were supposed to be inseminated with donated sperm from a same skin colour's donor, unless a special request is made for them. The error of the medical centre was to have fertilized eggs of the mother of the applicants with male gametes marked by the nomenclature "Caucasian (Cape coloured)", which refers to a South African community including different skin colours, A and B therefore had skin colours that were markedly different from their parents, and different from each other, differences that as they grew older, became more obvious.

The applicants brought claims for damages, saying that:

> *"The plaintiffs have been the subject of abusive and derogatory comment and hurtful name calling from other children, causing emotional upset. Further, the plaintiffs have been the subject of adverse and hurtful comments from others, both*

71 High Court of Justice in Northern Ireland Queen's Bench Division Decisions *A (A Minor) & Ors. v A Health & Social Services Trust* [2010] NIQB 108 (13 October 2010)
available at: http://www.bailii.org/nie/cases/NIHC/QB/2010/108.html

directed at them and overheard, about the colour of their skin, the difference between the plaintiffs and about the difference between the plaintiffs and their parents. This causes emotional upset. The plaintiffs have questioned their parents about whether they were adopted. Should either of the plaintiffs go on to have a child with a partner of mixed race any child born to them is likely to be of different skin colour than either parent. The quality of the life of the plaintiffs and each of them has been adversely affected. They may suffer loss and damage."

The first difficult question the court had to consider was whether or not the defendant owed the claimants a duty of care at the time of the mistake. The judge Gillen J considered that the common law position with the right of the baby was settled by *Burton v. Islington HA*[72], he explained that there is a duty to take care not to cause damage to it while still in its mother's womb, and a child is deemed to possess at birth of all the rights of action which it would have had if it had possessed legal personality at the date of any accident befalling its mother. Another point was the duty of care owed to human cells, this would have had much wider ethical and legal implications than IVF treatments if it had been considered. Once again we see that English law does not protect the gametes or embryo, but only the baby once it has been born has its own rights. The judges' words to deny the protection of the applicants were that:

"It seems to me that it is for Parliament to grasp the nettle of whether there ought to be a duty of care owed in the circumstances postulated in this case. For my own part, sitting

72 ENGLAND AND WALES COURT OF APPEAL (CIVIL DIVISION) *Burton v Islington Health Authority* [1992] EWCA Civ 2 (18 March 1992) Available at: http://www.bailii.org/ew/cases/EWCA/Civ/1992/2.html

as a judge at first instance, I do not believe that it is appropriate for a judge to stretch the common law principle inherent in Burton to embrace human cells as conferring the relevant status for a duty of care to be owed. It is for Parliament, after the appropriate social, moral, medical and ethical arguments have been aired, to define the limits of protection which should be accorded in such circumstances. It would be inapposite for this court to usurp that function. Absent the imprimatur of Parliament I am not content to find that these plaintiffs have sufficient status to be owed a duty of care."

The second question to face for the court was that of "loss and damage". Here the essential issue was the skin colour of the two young children because they were both perfectly healthy. This incident did not cause them any physical health problems. Gillen J considered the skin colour a normal character of a person, saying:

"In a modern civilised society the colour of their skin – no more than the colour of their eyes or their hair or their intelligence or their height – cannot and should not count as connoting some damage to them"

To support that a different skin colour is an injury would be contrary to the fundamental principles of a contemporary and multi-ethnic society, as well as a negative consequence for the self-esteem of the brothers. The presence of persons sufficiently cruel as to issue racist comments directed at these children is no basis for a conclusion that they are somehow damaged by the clinic.

The conclusion was that the claimants have not suffered any legally recognisable "loss or damage" connected to the mistake caused by the defendant, so he had no civil obligations towards them.

The solution ruled by the English court, however, may not have come to the same conclusion if the human rights of the child had been taken into consideration in this case.[73]

3. SURROGACY

Surrogacy allows couples, a single man or a single woman who are unable to conceive or carry a child themselves another possibility. As in the case of heterologous fertilisation, surrogacy involves a third person, a woman, not as a donor but as the carrier of the child. As of 2010 same sex couples can also legally use surrogacy as a means to have a baby.[74]

In surrogacy, another woman remains pregnant for a person or couple who want a baby. When the child is born, the woman carrier gives the child to them.

There are two types of surrogacy: "traditional or straight" and "host"[75].

The simplest form of surrogacy is known as "traditional surrogacy". This can be done in private without the assistance of a clinic. In this case the sperm is from the intended father and ova from the surrogate mother. The mother can fall pregnant in the traditional way or through sperm injection, the self administered technique.

"Host surrogacy" is another alternative which is more expensive and invasive for the surrogate mother. It can only take place in a fertility clinic because the gametes implanted in the carrier mother are not her

73 P. Passaglia con contributi di E. Bottini, C. Guerrero Picó, S. Pasetto e M. T. Rörig., La Fecondazione Eterologa. Available at: http://www.cortecostituzionale.it/documenti/convegni_seminari/CC_SS_fecondazione_eterologa_201406.pdf

74 The Human Fertilisation and Embryology Act 2008 enables same sex couples to apply for a parental order. This part of the Act will come into apply in April 2010.

75 http://www.hfea.gov.uk/fertility-treatment-options-surrogacy.html#3

own. The procedure to obtain a “host” surrogate pregnancy takes longer and more medical care is required, when compared to the “straight” surrogacy method.

Once the interested parties find a surrogate mother, she must come to the clinic with the applicants in order to start the procedure. It is not the clinic's responsibility to procure a surrogate for the intending parents. There are websites and organisations that can be helpful in finding a surrogate, some are more secure such as the UK no-profit surrogacy organisation[76] and others, less secure such as surrogacy websites.

The clinic begins the process by regulating the surrogate's hormones with fertility drugs and submitting her to vaginal and health controls to confirm that she is the right candidate.

Once these tests are completed and the clinic is satisfied with the results, it starts the procedure to prepare the ova and sperm for the fertilization.

There are three ways to do the implantation procedure: by using the eggs and sperm of the intended parents; from a donated egg fertilised with the sperm of the intended father; or by an embryo which has been created with donors' eggs and sperm. When both mother and embryos are ready, up to two embryos are implanted in the uterus of the surrogate mother. If any other embryos are remaining, they are frozen for possible later use. Ten-fourteen days after the pregnancy may be confirmed if successful.

If the procedure is unsuccessful, the surrogate is advised to stop taking all medication, but if the intended parents wish to, a new IVF cycle can start.

3.1 EVOLUTION OF REGULATION

76 http://www.surrogacyuk.org

Before the Warnock Committee and to date, a limited number of regulations have been issued on surrogacy. This practice is not specifically regulated by UK law, however it is tolerated and some rules have been issued to protect the surrogate mother and any child that may be born from this procedure.

The UK Parliament began to look at the issue of surrogacy in particular after the 1985 *"Baby Cotton Case"*. In this situation an American couple found a surrogate mother in England through an agency and she was inseminated by the sperm from the intended couple's husband. The agreement was that once the child was born, the surrogate mother would give the new baby to the American couple. A problem occurred however, when the couple went to England to take the baby home with them. The local authority was in doubt as to whether they could legally grant expatriation of the baby and subsequently requested a court ruling to clarify the situation.

The court ruled that in the best interests of the child, the American couple would take him back to the USA with them. The decision was based on the fact that when a child is born through surrogacy and the surrogate mother does not want the child, the commissioning parents are allowed to take care of the child, if they can offer a suitable home.

The judge also explained his concerns regarding the commercial aspect of this case, in which a woman had received money for giving birth. He did not however, argue this particular detail of the arrangement in the sentence delivered but noted that this practice of exchange of money is completely different from the law which governs adoption, where no financial gains are permitted.[77]

Section 57 of the Adoption Act of 1976 stipulates that:

77 Shirley R. Jones and Rosemary Jenkins, The Law and the Midwife, UK, John Wiley & Sons, 15 April 2008 second edition, at145

it shall not be lawful to make or give to any person any payment or reward for or in consideration of –

(a) the adoption by that person of a child;

(b) the grant by that person of any agreement or consent required in connection with the adoption of a child;

(c) the [F107handing over of a child by that person] with a view to the adoption of the child; or

(d) the making by that person of any arrangements for the adoption of a child.

However under section 57(3), it should be noted that a judge is granted the power to authorise payments where appropriate.

In 1987 the same judge that presided over the "*Baby Cotton case*" Mr Justice Latey, ruled in another surrogacy hearing in which he did grant payment. In this instance a couple had agreed to pay a woman £10.000 to carry and give birth to a baby conceived by the surrogate mother. The surrogate became pregnant through a normal sexual relationship with the husband of the committed couple.

The case was *Re an Adoption Application ((Surrogacy) [1987] Fam 81)*[78].

The arrangement "was fully honored on both sides".

The judge was called on to rule if the payment to the surrogate mother was unlawful due to a violation of the Adoption Act. He ruled that the payment could be considered as compensation for the inconvenience and expenses incurred by the surrogate mother during the pregnancy. It was not to be considered as a previous payment for the future baby's adoption.

78 Surrogacy. Review for health ministers of current arrangements for payments and regulation. Report of the review team.
Available at:
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4014373.pdf

In conclusion, without having any detailed regulation by Parliament as to what exactly constitutes an expense, the "expenses" incurred during a surrogate pregnancy can become an almost limitless list, difficult for any court to prove and define.

The first law which was enacted to avoid the creation of a market of "wombs for rent" was the Surrogacy Arrangements Act of 1985, five years before the Human Fertilisation and Embryology Act of 1990.

The Surrogacy Arrangement Act gives the definitions of a surrogate mother, surrogate arrangement and other connected terms. Ultimately the Act attempts to control the aspect of the commercial trade of these activities. Surrogacy is considered to be an act of the body, any type of business or control of it is considered to be an offence, and punishable as such by Law. Only arrangements "on a commercial basis"[79] are covered by this Act. Any other issues in surrogacy arrangements were not taken into consideration until Section 36 of the Human Fertilisation and Embryology Act of 1990 was issued. This was an amendment of the Surrogacy Arrangement Act of 1985:

> "*No surrogacy arrangement is enforceable by or against any of the persons making it.*"

This lack of enforceable surrogacy laws regards both the surrogate mother and the intended parents. It is not possible for any of the parties who have entered into a surrogacy contract to sue forcing adherence to the agreement. The woman who gives birth is always treated as the mother under UK law. She has the right to keep the child and be the effective mother of the baby, even if she is not

79 Section 2(3) of the Surrogacy Arrangement Act 1985 says that:
«For the purposes of this section, a person does an act on commercial basis if:
a) any payment is at any time received by himself or another in respect of, or
b) he does it with a view to any payment being received by himself or another in respect of making, negotiating or facilitating the making of, any surrogacy agreement. In this subsection 'payment' does not include payment to or for the benefit of a surrogate mother or prospective surrogate mother»

genetically related to the child. Thus the intended parent has no rights over the child. The birth is registered with the surrogate mother's name and if she is married, with her husband's name. If the surrogate is not married a biological father can be immediately registered as the legal father.

In other circumstances where the intended parents may not want the child born from the surrogacy the agreement is not enforceable by court and the surrogate mother cannot sue them. For this reason the trust of both parties is of up most importance and essential in any surrogacy arrangements in the UK. It is also one of the reasons that pushed English people who want to use surrogacy treatments, to go abroad to find surrogate mothers.[80]

An important rule was introduced in the 1985 Act to avoid the marketing of wombs and women in particular. This rule punishable by law was brought in against commercial intermediaries, persons or agencies that agree to a woman's performance and surrogacy. This Act penalized any form of direct advertising to promote the conclusion of such agreements.[81]

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80 In other countries, such as India, the surrogacy arrangement has a legal value that ensure both parties. An interview from The BBC Megazine explains well the reasons of many people who ask abroad the surrogacy:
"Bobby and Nikki Bains, a Sikh couple who live in Essex, went there after finding out Nikki could not have children. They wanted an Asian egg donor and an Asian surrogate, and it was hard to find either in the UK.
In India you need a legally binding contract before you start the surrogacy process. Surrogates can only be "womb carriers" - they cannot be genetically related to the baby.
"If the baby is disabled or even if you become disabled, who's going to be the next of kin, who's going to look after baby? All that is pointed out in the surrogacy contract," says Bobby.
He defends payments to surrogates, who are limited to carrying other people's babies twice.
"These surrogates in India or the ladies that want to do surrogacy know what they're getting themselves into. I think most people go to do a job. Most people go to work because they need the money."
From: http://www.bbc.com/news/magazine-28864973

81 Surrogacy Arrangement Act 1985, Section 2:
Negotiating surrogacy arrangements on a commercial basis, etc.
(1)No person shall on a commercial basis do any of the following acts in the United Kingdom, that is—

This provision however did allow for no-profit organisations, which puts surrogate mothers in contact with people who want to have a baby through surrogacy.

The Human Fertilisation and Embryology Act 2008 in Part 3, Section 59, also states today that these no-profit organisations can ask reasonable rates to pay for the cost of their activities.

Before the drawing up of the 2008 Act, a commission was set up in 1997 by the United Kingdom Health Ministry, the Brazier Commission named after the chairwoman, Margaret Brazier. The purpose of this commission was to review the controversial themes of surrogacy. The committee focused their attention on: the payment of surrogate mothers; whether an agency could regulate the surrogacy arrangement and if the existing regulations needed to be modified.

In the Report the review team reconstructed what has been the UK Surrogacy Experience to date and defined the problem of a surrogate's payment. They examined this issue whilst considering that any payment made contravened the norm that no body part could be sold or intimate services be paid for.

They found that these prohibitions to sell the body or the services of such appear to be ignored when surrogacy agreements are made between the parties concerned. When a commissioning couple

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(a)initiate or take part in any negotiations with a view to the making of a surrogacy arrangement,
(b)offer or agree to negotiate the making of a surrogacy arrangement, or
(c)compile any information with a view to its use in making, or negotiating the making of, surrogacy arrangements;

and no person shall in the United Kingdom knowingly cause another to do any of those acts on a commercial basis.

(2)A person who contravenes subsection (1) above is guilty of an offence; but it is not a contravention of that subsection—
(a)for a woman, with a view to becoming a surrogate mother herself, to do any act mentioned in that subsection or to cause such an act to be done, or
(b)for any person, with a view to a surrogate mother carrying a child for him, to do such an act or to cause such an act to be done.

applies for a parental order or adoption however these payments come into question. They concluded that surrogates had been paid a fee which was over and above the "expenses" of their pregnancy. As a solution the Committee listed the hypothetical expenses which could be incurred during the pregnancy[82]

The second point reviewed by the committee was regarding the involvement of agencies in surrogacy arrangements. They proposed that the Health Department should monitor these no-profit agencies. The committee gave three suggestions for how surrogacy agreements could be regulated: Extend the Role of the Human Fertilisation and Embryology Authority (HFEA); the establishment of a licensing authority specifically for the oversight and control of surrogacy; the registration of all agencies in a UK Health Department register to ensure all operations respect a Code of Practice.

These solutions proposed by the Brazier Committee required the creation of a new Surrogacy Act however, the recommendations of the Brazier Report were never put into practice and included in The Human Fertilisation and Embryology Act of 2008. Once again all the issues surrounding surrogacy had not been properly regulated.

Only few aspects of surrogacy were taken into account in the 2008 Act, such as the legal provision that no-profit agencies can have expenses refunded for their activities. An amendment was passed on 6 April 2010 which allowed unmarried and same sex couples the possibility to make an application for a parental order. This new rule was retrospective for the first six months, which meant that gay couples who were already carrying a child conceived through

82 Maternity clothing; Counselling fees; Healthy food; Legal fees; Domestic help; Life and disability insurance; Travel to form hospital/clinic; Medical expenses; Telephone and hospital expenses; Ovulation and pregnancy tests; Overnight accommodation; Insemination and IVF costs; Child care to attend hospital/clinic; Medicines and vitamins.
If the surrogate mother is employed when she enters into the surrogacy arrangement and has to take time off work in connection with the pregnancy or birth, her actual loss of earning should be reimbursed. The time taken off work should be in accordance with medical advice and statutory guidelines.

surrogacy before that date had until 5 October 2010 to apply for a parental order.[83]

For payment of the surrogate mother the law excludes that a woman can be paid for surrogacy but she must have a reasonable payment for expenses occurred during her gestation period. Every situation is different and how much is needed must be discussed in detail before finalising a surrogacy arrangement. The law does not give a precise value as to how much a surrogate can receive for these gestational costs, although this provision would be well received. The payments to surrogates are currently around £12.000/£15.000[84].

3.2 PARENTHOOD OF CHILDREN BORN FROM SURROGACY

Surrogacy as already shown is a complex subject and the law has substantial oversights. For these reasons the same HFE Authority recommends getting legal advice before any party makes a decision regarding surrogacy treatments.

The biggest problem is regarding motherhood and fatherhood of the child born from surrogacy.

In the UK the fundamental legal aspect of motherhood is the gestational relationship between the mother and the foetus. This is what was established by the Heterologous Fertilisation Rules. Problems occur because the surrogate mother has the natural link with the baby yet the purpose of surrogacy is to find another womb for those who cannot carry a child themselves. The UK laws do not

83 Human Fertilisation and Embryology (parental orders) Regulations 2010 http://www.legislation.gov.uk/uksi/2010/985/made

84 Emily Jackson , Medical Law: Text, Cases, and Materials, Oxford University Press, 2013, at 861

take into account the fact that the carrier is the "third person" and should not be the one who keeps the child after the birth.

The surrogate, as the woman giving birth, will be the legal mother of the child and will be nominated as such on the birth certificate. She will have the parental responsibilities until the intended parent applies through the courts for a parental order or adoption[85].

If the surrogate mother is married or in a civil relationship at the time of the treatment, her partner will be the second legal parent of the child born, unless it can be shown that the mother's partner did not consent to the surrogacy. This situation is slightly different when the surrogate is single or her partner does not consent to treatment or they are separate. The intended parent, who at the same time is the biological father of the child, would be automatically recognized as the legal parent under common law.

From 1 October 2013, the HFE Authority changed its Guidelines and created a new consent form on legal parenthood. This opened the way for intended parents involved in surrogacy arrangements enabling one of them to automatically become one of the legal parents of the baby at birth:

> *As of 1 October 2013, it will be possible for one of the intended parents commissioning a surrogacy arrangement to be recognized as the legal parent when the child is born, if the surrogate is not married or in a civil partnership and the relevant consents are in place.*[86]

85 Human Fertilisation and Embryology Act 2008; Section 33: Meaning of "mother"

86 Guidance; Surrogacy and legal parenthood – changes from 1 October 2013 http://www.hfea.gov.uk/7962.html

Therefore just by completing the new consent form, any person can be the parent of a surrogate child without being in a biological relationship with the baby.

3.3 THE PARENTAL ORDER

The intended parent who is to become the legal parent of the baby born from the surrogate mother has two possibilities: to ask a court for the parental order which has procedural requirements to respect to have it issued, or to apply for adoption if the parental order prerequisites cannot be met.

The intended parents (both or just one, if the other already has legal parenthood) can apply to the court within six months of the birth of the baby for a parental order, as provided under Section 54 of the Human Fertilisation and Embryology Act of 2008. This order transfers the legal rights from the surrogate and legal mother to the committed parents. The applicants must make the order in a Family Proceeding Court by depositing the specific form. The court then sets a date for the hearing[87].

Section 54 of the 2008 Act contains the conditions that must be met in order to request a parental order:

> *(1)On an application made by two people ("the applicants"), the court may make an order providing for a child to be treated in law as the child of the applicants if—*
>
> *(a)the child has been carried by a woman who is not one of the applicants, as a result of the placing in her of an embryo or sperm and eggs or her artificial insemination,*

87 https://www.gov.uk/become-a-childs-legal-parent

(b)the gametes of at least one of the applicants were used to bring about the creation of the embryo, and

(c)the conditions in subsections (2) to (8) are satisfied.

(2)The applicants must be –

(a)husband and wife,

(b)civil partners of each other, or

(c)two persons who are living as partners in an enduring family relationship and are not within prohibited degrees of relationship in relation to each other.

(3)Except in a case falling within subsection (11), the applicants must apply for the order during the period of 6 months beginning with the day on which the child is born.

(4)At the time of the application and the making of the order –

(a)the child's home must be with the applicants, and

(b)either or both of the applicants must be domiciled in the United Kingdom or in the Channel Islands or the Isle of Man.

(5)At the time of the making of the order both the applicants must have attained the age of 18

The court must be sure that no money, excluding any reasonable expenses incurred, has been paid to the surrogate mother unless otherwise authorized by the court. The most recent case law is quite clear that the court authorises payments retrospectively, if they are not too disproportionate in relation to the reasonable expenses incurred.

To obtain that order it is also necessary to have the consent of the surrogate mother. Legal parenthood can only be transferred if the mother and the second parent agree to it.

The welfare of a child is of paramount concern to a court when granting a parental order. Its deliberations are based on the welfare criteria from the Children Act 2002.[88]If the order is granted it conditions not only the period of childhood, but the child's whole life. For this reason the court has an officer of "CAFCASS"[89] prepare a report. The officer must visit the family at home and talk to both intended parents. This meeting is presented in a report to the court, explaining if the conditions set out above have been met. The court must make its decision holding in consideration the best interests of the child. The release of a parental order changes the legal parenthood and parental responsibilities of the children. A new birth certificate is issued including the new parenthood and excluding the old ones, because in the UK only two parents can be recognized by law.

Any child born through a surrogacy arrangement, as with other IVF treatments, has the right to know about their origins. For this reason rule 13.16 of the Family Procedure Rule 2010 provides for disclosure of information to any child born from these practices at the age of eighteen.

Through application to the court, a child can have access to the following information:

> *(a)the application form for a parental order (but not the documents attached to that form);*
> *(b)the parental order and any other orders relating to the parental order proceedings;*
> *(c)a transcript of the court's decision; and*

88 Welfare Checklist, Section 1, Adoption and Children Act 2002 as applied by the 2010 Regulations

89 The Children and Family Court Advisory and Support Service (Cafcass) looks after the interests of children involved in family proceedings. http://www.cafcass.gov.uk/

(d)a report made to the court by the parental order reporter.[90]

3.4 THE INTERNATIONAL CONTEXT

The English law's position on surrogacy is different from some European countries, as Italy or Germany, which take a more restrictive approach, and other countries, such as US or India, that make this treatment much more accessible.

Some interested parents, who live in more restrictive countries, go to the UK as they are attracted by the possibility of easier access to surrogacy. At the same time some British couples looking for a surrogate mother drive abroad to a country with more liberal jurisdiction where they find commercial surrogacy is permitted, arrangements are legally enforceable and surrogates are freely available.

In consideration of this phenomenon the HFE Authority warns users of the issues and risks associated in doing the surrogacy abroad. In 2008 a paper on *"Cross border fertility treatment"*[91] published information about surrogacy outside the UK. This paper explains the issue and the services offered to the foreign commissioning, using a selection of sample Fertility Clinics in the world.

From a legal point of view, what are the implications of this trade of surrogacy?

Let's begin by observing the phenomenon of foreign couples coming to the UK for treatment. The difficulty of finding a surrogate mother is something not to be underestimated also due to the scarce legal

90 http://www.legislation.gov.uk/uksi/2010/2955/article/13.16/made

91 http://www.hfea.gov.uk/docs/AM_Item3_Dec08.pdf

value of arrangements between the parties. The foreign intended parents must find a woman they can trust and vice versa because, as already stated, the position of the surrogate mother is not protected by law after the birth of the baby.

Other difficulties, once they find the surrogate and after the birth of the child, are requirements that must be respected for issue the parental order. The 2008 Act requires that "*either or both of the applicants must be domiciled in the United Kingdom or in the Channel Islands or the Isle of Man",* which means that if a commissioning couple does not satisfy the domicile requirement, a parental order will not be available.

This is happened in 2007, in the case *Re G (Surrogacy: Foreign Domicile) [2007] EWHC 2814 (Fam)*[92].

Judge McFarlane had to decide the parentage and future upbringing of a child born out of a non-commercial surrogacy arrangement where the commissioning parents were domiciled in Turkey.

The married couple, Mr and Mrs G, is Turkish nationals and domiciled in Turkey. They traveled to the UK and conceived a baby girl M with a British surrogate mother, born on 29 September 2006.

According to the rules in the parental order application form the intended parents could not apply due to their nationality. For this reason the case was taken to the High Court.

Unfortunately, the agency which they had used, a British surrogacy agency named COTS (Childlessness Overcome Through Surrogacy), had said to them that they could apply for the order. In the past, other foreign couples had successfully obtained the order, unbeknown to them however that it was not legal. In this case the Judge denied the concession of a parental order to Mr and Mrs G.

92 *Re G (Surrogacy: Foreign Domicile)* [2007] EWHC 2814 (Fam) available at: http://www.familylawweek.co.uk/site.aspx?i=ed984

After nine months of litigation, the case was resolved in favor of the commissioning parents:

> *The aim of the court has therefore been to identify and establish the most effective legal structure, short of a parental order, that can facilitate Mr and Mrs G in due course adopting M in their home country.*
> *In the event this was achieved by making an order under ACA 2002, s 84*
> *…*
> *By ACA 2002, s 84(2) the High Court may, on an application by persons who the court is satisfied intend to adopt a child under the law of a country or territory outside the British Islands, make an order giving parental responsibility for the child to them.*

In his conclusion Mr Justice McFarlane warned that English law should not be used by foreign couples seeking to evade more restrictive home legislation. He advised any future applicants of the need for strict observation of UK law regarding parental orders.
The situation is not any easier for British couples who go abroad for surrogacy.
In some countries the enforceable agreement allows the committed parents to be named on the foreign birth certificate. However problems start when the couple, recognized as the legal parents in another country, comes back to England calling for the recognition of the same parentage. Here the court has to apply the UK law, the rules regarding the parental order, the Human Fertilisation and Embryology Acts' parenthood provisions and the prohibition of an arrangement on a commercial basis.

In the case of *Re K (Minors: Foreign Surrogacy) [2010] EWHC 1180 (Fam)*[93] the application was made even though the children had not been granted entry clearance into the UK.

The case involved twins born in May 2009, as a result of a foreign commercial surrogacy arrangement between the applicants resident in the UK and a married couple in India. At the time of the application the children were in India at the home of the grandparents. The UK applicants of Indian origins but resident in the UK asked to a parental order to recognize them as the parents.

The children were conceived using an egg from a donor and the sperm of the man of the committed couple. The arrangement recognized the British couple as the parents of the twins.

The case was adjourned with the possibility to proceed only if and when the children were in the jurisdiction of the UK court.

> *The UK Border Agency has now issued guidance known as "Inter-Country Surrogacy and the Immigration Rules". The relevant part of the Guidance is paragraph 41 which reads as follows:*
>
> *"If either of the commissioning couple has a genetic connection with the child, entry outside the Rules at the discretion of the Secretary of State may be possible, but such entry clearance will only be granted on condition that a section 30 parental order is applied for within 6 months of birth and where evidence suggests that such an order is likely to be granted…"*

93 *Re K (Minors) (Foreign Surrogacy)* [2010] EWHC 1180 http://www.familylawweek.co.uk/site.aspx?i=ed66427

The genetic relationship was established and the application was made within the required time. Judge Hedley expressed considerable unease in drawing any conclusions as to the likely success of the application, because the children were not resident in the UK. The court had no jurisdiction over them. The law requires that the welfare of the children must be taken into account by observing them with the applicant parent whilst living in UK. The court also had to approve the payment for the arrangement.
Mr Justice Hedley concluded that, the court could not take into account the request of the applicant:

> *"If and when the children are in the country (and only then) can the court proceed further with this application"*

Another problem, rose in this case but not ruled on (but decided by the same judge Hedley in the *Re X & Y (Foreign Surrogacy) [2008] EWHC 3030 (Fam)*[94]), was the commercial payment that had been made to the surrogate mother. Section 54 of the 2008 Act explained that the court has the power to authorize a payment in excess of the costs incurred for the pregnancy. The difficulty for the court, when it is asked to authorize the payments, is the fact that the child has already been born and its welfare weighs against the public policy imperative of prohibiting commercial payments. In the case of *X & Y* the Judge expressed this particular problem with payment and the court's role in this proceeding:

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94 *X & Y (Foreign Surrogacy)* [2008] EWHC 3030 (Fam)
In this case a British couple A couple had made a surrogacy arrangement with a Ukranian woman who gave birth to twins using anonymously donated eggs fertilised by the male applicant's sperm. Although the commissioning parents were treated as the legal parents in the Ukraine and named on their birth certificate, instead the English surrogacy law did not recognize their parental status and so did not allow them to confer British citizenship status on the children. http://www.familylawweek.co.uk/site.aspx?i=ed28706

> *"I feel bound to observe that I find this process of authorization most uncomfortable. What the court is required to do is to balance two competing and potentially irreconcilably conflicting concepts. Parliament is clearly entitled to legislate against commercial surrogacy and is clearly entitled to expect that the courts should implement that policy consideration in its decisions. Yet it is also recognized that as the full rigour of that policy consideration will bear on one wholly unequipped to comprehend it let alone deal with its consequences (i.e. the child concerned) that rigour must be mitigated by the application of a consideration of that child's welfare. That approach is both humane and intellectually coherent."*

In the absence of a Parliamentary revisions the most recent courts decisions have been based exclusively on the welfare of the child rather than any monetary issues. At the time of application for a parental order the court must be informed of any commercial agreement between the parties involved in the surrogacy, however the child interest is of prime concern before any economical interests that may arise.

THE U.S. APPROACH TO THE ASSISTED REPRODUCTION

Reproductive technologies include techniques, like IVF, which help infertile people achieve pregnancy, or techniques that modify embryos for scientific purpose, such as the creation of chimeric-embryos or the reproductive cloning.

ART appears to be very accessible in the United States. The US media exposure on this subject at an international level would suggest a large amount of the legislation regulating these activities.

On the contrary, there is a not a great deal of regulation both at the federal and at the state level on this subject. In the U.S. we would rather talk about non-regulation.

Another issue that must be taken into account is the presence of American Constitution, something that does not exist in England.

The silence of the federal and most state governments is supported by a complete lack of legal relies. There is a lack of a unilateral jurisdiction, and no system of precedents that demonstrate the right way to follow in the absence of statutes.

From the 1970 until the beginning of the new millennium several blue-ribbon commissions[95] were established in the United States to analyze these subjects. However there was not the necessary political

95 Blue ribbon commission is a group of exceptional people appointed to investigate or study or analyze a given question, often appointed by a government body. It might be composed of independent scientific experts or academics with no direct government ties to study a particular issue or question, or it might be composed of citizens well known for their general intelligence and experience.

support to convert their findings into law[96] and the work of these commissions was never used.[97]

The technologies used for ART are in evolution and have a big area of action. Therefore it is extremely difficult to establish laws which regulate and are up to date with all the factors that are involved in this field.

Neither the Constitution of the United States (1787) nor the subsequent amendments contain rules regarding the practices of assisted reproduction. However the theme finds its legal loophole through constitutional interpretation.

The right of reproduction is protected by the U.S. Constitution under the fifth and fourteenth amendment:

> ***Right to privacy: personal autonomy***
>
> *The right of privacy has evolved to protect the freedom of individuals to choose whether or not to perform certain acts or subject themselves to certain experiences. This personal autonomy has grown into a 'liberty' protected by the Due Process Clause of the 14th Amendment. However, this liberty is narrowly defined and generally protects privacy of family, marriage, motherhood, procreation, and child rearing. There have been attempts to further extend the right of privacy under the 1st, 4th, and 5th Amendments to the U.S. Constitution; however, a general right to personal autonomy has yet to take hold beyond limited circumstances.*[98]

96 Margaret Foster Riley with Richard A. Merril
The Columbia, 2005, Science and Technology Law Review, volume VI
Regulating reproductive genetics: a review of American Bioethics commission and comparison to the British Human Fertilisation and Embryology Authority, at 4-5-6
www.stlr.org

97 Id. at 60-63; the text search an explanation on the reasons why in the US there aren't enacted legislation to regulate the ART

98 http://www.law.cornell.edu/wex/personal_autonomy

As cited above the right to privacy has been expanded to include any cases dealing with reproductive rights to be applied to the area of assisted reproduction.

The right to privacy has evolved in two directions: the positive right which involves the possibility for any person to be alone to make their own decisions, and the negative prospective which is that they can act without government interference.

However this right to privacy does not mean that the government has the duty to offer assistance when a person acts on this Constitutional right.

As is shown by the words of the *Supreme Court in Harris v. McRae, 448 U.S. 297 (1980):*

> *"The liberty protected by the Due Process Clause...does not confer an entitlement to such funds as may be necessary to realize all the advantages of that freedom."*[99]

Rights that can be translated, in reference to ART, such as the right of a person to be free to decide on whether to use artificial insemination and other reproduction techniques. On the contrary there is no obligation of the State to give people the means to have access to these treatments.

99 http://supreme.justia.com/cases/federal/us/448/297/case.html#317
Pp. 448 U.S. 317-318.

1. THE RIGHT TO PROCREATE AND THE U.S. SUPREME COURT INTERPRETATION

The U.S. Supreme Court refers to the right to procreate as the right to have or not have a baby. It is considered a fundamental right of every person.

The ongoing of cases which use the Supreme Court's interpretation of the Constitutional right to procreate regarding interruption or avoidance of pregnancy by contraceptives use and the right to terminate a gestation prior to viability for any reason, or after viability in order to protect the woman's life or health.[100]

The use of assistive reproduction corresponds to the right to procreation, not the right to avoid pregnancy. These judgments of the Supreme Court promote the opposite right, to avoid gestation, so the extension to ART requires a contrary interpretation.

There are precedents which however refer directly to the Right to Procreate, or rather the limitation of that right.

The first date back to the 1927 was the *Buck v. Bell, 274 U.S. 200 (1927)*[101].

100 See: *Griswold v. Connecticut*, 381 U.S. 479 (1965) in which Supreme Court declared unconstitutional a Connecticut Statute that prohibits "any drug, medicinal article or instrument for the purpose of preventing conception." ; *Eisenstadt v. Baird*, 405 U.S. 438 (1972) in which the Court removed the unequal Massachusetts' Law which deny the right of the unmarried people to posses contaceptions;
Roe v. Wade, 410 U.S. 113 (1973) in which the Supreme Court decided that the Texas statute which states criminal abortion is a violation of the Due Process Clause of the Fourteenth Amendment.

101 *Buck v. Bell*, 274 U.S. 200 (1927)
https://supreme.justia.com/cases/federal/us/274/200/case.html

It was a case which followed the eugenic's movement[102], a doctrine about the real possibility of improving the quality of the human race using selective reproduction.

An Act of Virginia approved on 20 March 1924 (Laws 1924, c. 394), stated that the health of the patient and the welfare of society may be promoted in certain cases by the sterilization of mental defectives.[103]

Under this law, Carrie Elizabeth Buck the plaintiff, who was considered feeble minded, sued Bell, the superintendent of the State Colony for Epileptics and Feeble Minded, following an order to perform an operation which would have make her daughter sterile and her.

In 1923 she became pregnant as the result of being raped, by the nephew of her foster parents. That pregnancy was considered a sign of her promiscuity and feeble-mindedness. In fact Carrie was a child born out of wedlock, from Emma Buck, a woman considered to have been a "low grade moron" and promiscuous.[104]

Applying the Virginia Act on September 1924, superintendent Priddy (the superintendent before Bell) approved a list of sixteen candidates for sterilization, one of whom was Carrie Buck.

The Act seemed to give every assurance of procedural due process. In fact the superintendent was require to petition a special board of his hospital and to file an affidavit with respect to the facts he

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102 The study of or belief in the possibility of improving the qualities of the human species or a human population, especially by such means as discouraging reproduction by persons having genetic defects or presumed to have inheritable undesirable traits (negative eugenics) or encouraging reproduction by persons presumed to have inheritable desirable traits (positive eugenics)

103 In the course of the next generation, the Commonwealth of Virginia, which coercively sterilized more than eight thousand persons, became the second leading state in the country in this procedure, surpassed only by the considerably more populous State of California. The Supreme Court Reborn: The Constitutional Revolution in the Age of Roosevelt at the end of six paragraph

104 http://encyclopediavirginia.org/Buck_v_Bell_1927#start_entry

presented. The patient had the right to appeal to the County Court, which would review the evidence before issuing the order. Lastly every party could sue in the Supreme Court of Appeals.

The young woman (she was eighteen at that time), before the sterilization, started the trial against that order in the County Circuit Court. The trial was brought in the U.S. Supreme Court in 1927.

The respondent here was Bell, the new superintendent of the State Colony for Epileptics and Feeble Minded, named after Priddy's death. In the Court the Virginia Act was claimed by the plaintiff Carrie Buck as unconstitutional. She stated that it was a violation of the due process clause of the XIV Amendment which deprived her of her constitutional right of body integrity, and the right to decide to procreate.

The Supreme Court delivered an 8 to 1[105] decision upholding the order to sterilize Carrie Buck and the law that authorized it.[106] The Court did not find any violation under the constitution and its amendment.

Mr Justice Holmes delivered the opinion of the Court, including some controversial sentences:

> *"Experience has shown that heredity plays an important part in the transmission of insanity, imbecility, …We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the State for these lesser sacrifices, often not felt to be such by those concerned, in order to prevent our being swamped with incompetence. It is better for all the world, if instead of waiting to execute*

105 Mr Justice Butler dissents.

106 William E. Leuchtenburg , The Supreme Court Reborn: The Constitutional Revolution in the Age of Roosevelt; One Mr Justice Holmes and Three Generation of Imbeciles, Oxford University Press, 06 April 1995, paragraph from 1 to 6

degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind…Three generations of imbeciles are enough."

In reference to ART the lesson to be learn, from the *Buck v. Bell* underlined, is that the State have the power. It can decide when or never allow people to procreate, also when there are other fundamental rights, such as in the *Buck case*, to protect the welfare of the society over and above the individual right to procreate.[107]

Buck has never been explicitly overruled. Today a law which enforces people to be sterilised would be not conceivable.

Another case from the 40s, which reaffirmed the principle of the Buck case was *Skinner v. Oklahoma.* [108]

The U.S. Supreme Court did not deny the power of the State to regulate procreation, but in doing so it should have respected the principle of equality before the law.

In 1935 the Habitual Criminal Sterilization Act was passed in Oklahoma. Under that Act any habitual criminal "*who, having been twice convicted...of crimes amounting of felonies involving moral turpitude, is thereafter convicted...of a crime involving moral turpitude*", would be subject to sterilization.

Mr Skinner, who has been convicted twice of armed robbery, and in 1926 of the crime of stealing chickens, was considered habitual criminal and therefore under that Act had to be sterilized.[109]

107 There are rights and powers "not delegated to the United States," and reserved to the states, under the Tenth Amendment of the U.S. Constitution: *"The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."*

108 Skinner v. Oklahoma ex rel. Williamson, 316 U.S. 535 (1942) https://supreme.justia.com/cases/federal/us/316/535/case.html

109 Susan Merril Squier, Poultry Science, Chicken Culture: a Partial Alphabet,Rutgers University Press, 2011, at 193

He challenged the Act as unconstitutional by reason of the Fourteenth Amendment.
In front of the Supreme Court the *Skinner case* was decided for the petitioner:

> *"We are dealing here with legislation which involves one of the basic civil rights of man. Marriage and procreation are fundamental to the very existence and survival of the race"*

The State, putting a limit to this right, for public welfare, has to respect the Equal Protection Clause and the Fourteenth Amendment[110].
The Oklahoma Act did not however place the same limitation on the freedom to procreate, for all similar situations were treated in different ways. In the words of Justice William Douglas:

> "*A person who enters a chicken coop and steals chickens commits a felony (id., § 1719), and he may be sterilized if he is thrice convicted. If, however, he is a bailee of the property and fraudulently appropriates it, he is an embezzler. Id., § 1455. Hence, no matter how habitual his proclivities for embezzlement are, and no matter how often his conviction, he may not be sterilized. Thus, the nature of the two crimes is intrinsically the same, and they are punishable in the same manner."*

110 *Yick Wo v. Hopkins, 118 U. S. 369. "Nor shall any State deprive any person of life, liberty, or property without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."*
These provisions are universal in their application to all persons within the territorial jurisdiction, without regard to any differences of race, of color, or of nationality, and the equal protection of the laws is a pledge of the protection of equal laws.

The Supreme Court ruling in the *Skinner case* did not say anything different to the *Buck case*. If the statute of Oklahoma had been written in a way where the fundamental rights were respected, the eugenics' decision to sterilize Mr Skinner would have taken place, as many years before with Miss Buck.

All these cases demonstrate that the Right to Procreate for the Federal Supreme Court is the decision of each individual US State.

Until today there has not been a judgement from the U.S. Supreme Court on assisted reproduction.

2. THE ONLY FEDERAL INTERVENTION: FERTILITY CLINIC SUCCESS RATE AND CERTIFICATION ACT

On December 1981 Elizabeth Carr, America's first baby conceived from IVF treatment, was born.[111]

After that birth there has been an increasing use of these treatments. In response to the doubts about the procedures of reproductive technology and the certification of the laboratories, the US Congress enacted the federal legislation Fertility Clinic Success Rate and Certification Act of 1992 (FCSRC or Public Law 102-493)[112].

This Act took effect two years after the date of its enactment. The purpose of the Act is to make clinics performing ART provide annually data for all procedures performed to the Secretary of Health and Human Service, through the Centers for Disease Control and

111 From Elizabeth Comeau story in The Boston Globe available at: http://www.boston.com/news/health/articles/2010/08/06/a_first_for_the_first/

112 The Fertility Clinic Success Rate and Certification Act 1992 PUBLIC LAW 102-493-OCT.24, 1992; http://www.gpo.gov/fdsys/pkg/STATUTE-106/pdf/STATUTE-106-Pg3146.pdf

Prevention (CDC). The other objective is to certify embryo laboratories. The model for the certification of the laboratories must be provided by the interested States.

The CDC's website has the organisations listed which currently offer non federal laboratory accreditation programs. These include: College of American Pathologist/American Society for Reproductive Medicine; the Joint Commission on Accreditation of Healthcare Organisation and the New York State Tissue Bank certification for ART laboratories.[113]

In 1996, the CDC began data collection regarding assisted reproductive technology procedures performed in the United States, as mandated by the Fertility Clinic Success Rate and Certification Act and published its first report in 1997. Since then, CDC has continued to publish annual surveillance report (latest is the 2012 Report).[114]

The CDC 'ART Success Rates Report is divided into 5 Sections.

They provide information on the success of the treatments, indicated by the data collected, and all the cycles of any type of treatments performed in United States clinics. The data also includes information about other factors which may be related to the patient or are out of the clinic's control. This information provides potential ART users with an idea of the possible success of the procedure and trends.

In order to have more precise reports the CDC cooperates with other organisation which collect data from the US clinics: the U.S. Department of Health and Human Services, the American Society for Reproductive Medicine (ASRM) and the Society for Assisted Reproductive Technology (SART).[115]

113 http://www.cdc.gov/art/patientresources/using.html

114 http://www.cdc.gov/art/patientresources/using.html

115 Id.

Another type of surveillance which is more complete and that gives more detailed data about the woman and children from ART, is undertaken with the collaboration of the Departments of Health of Connecticut, Florida, Massachusetts and Michigan.

This project started with the State of Massachusetts in 2001, and after was extended to other States, is named States Monitoring Assisted Reproductive Technology (SMART) Collaborative.

The SMART data set is used for both research (to monitor the state of heath of mothers and babies; to know the cause of death of the children and the mother comparing the ART data with the data of those who have not been subjected to these treatments) and surveillance.[116]

In addition to the FCSRCA the National Institute of Health has other guides governing research in reproductive treatment.

2.1 OTHER FEDERAL REGULATIONS

Together with the CDC other federal associations have regulatory responsibility on the development of ART: the Food and Drug Administration[117] (FDA), and the Centre for Medicare and Medicaid Services (CMS).

The FDA is responsible for protecting public health by assuring the safety and security of drugs, biological products and medical devices. Everyone, who works in reproductive medicine, can only prescribe medication approved by the FDA.

The FDA also has jurisdiction over screening and testing of reproductive tissue such as eggs, sperm and embryos implanted in humans, and issues the requirements for eggs and sperm donation[118].

116 http://www.cdc.gov/art/smart/index.html

117 http://www.fda.gov/default.htm

118 These regulations are insert in the Code of Federal Regulation, Title 21, volume 8, sec. 1271.

The activities of testing and research are ruled by the CMS.

The standards for all laboratories testing performed on humans in the United States, excluding clinical trials and basic research, are regulated by Center of Medicare and Medicaid Services under the Clinical Laboratory Improvement Act and its Amendments (CLIA)[119].

This Act regulates the jobs of the laboratories involved in reproductive medicine, with the exclusion of those that perform analysis for preimplantation genetic diagnosis. They are not subject to regulation like clinical laboratories under CLIA, but are under FDA control[120].

The purpose of the CLIA is to uphold the quality of laboratory testing by establishing standards on accuracy, reliability and timeliness of test results independently of where they are performed.

In the end, to assist medical centers to perform the assisted reproduction techniques, it is important to remember the role played by the professional medical associations, in particular the American Society for Reproductive Medicine (ASRM)[121].

This society is not only present in America (in all of the 50 States), but also in an international context. It is present in more than 100 countries and leads his activities in development and research with the support of the National Institute of Health.

Since 1950 the ASRM has been publishing a medical journal, Fertility and Sterility[122], which is an important reference for the

119 102 Stat. 2903, Public Law 100-578 http://www.gpo.gov/fdsys/pkg/STATUTE-102/pdf/STATUTE-102-Pg2903.pdf

120 Susannah Baruch, J.D., David Kaufman, Ph.D., and Kathy L. Hudson, Ph.D.; Genetic testing of embryos: practices and perspectives of US in vitro fertilization clinics; Genetics and Public Policy Center, Berman Institute of Bioethics of Johns Hopkins University, Washington, DC; Fertility and Sterility Vol. 89, No. 5, May 2008; at 1056.

121 https://www.asrm.org/?vs=1

122 http://www.fertstert.org/

physicians who are involved in reproductive techniques and the problems of human infertility. In that journal on 5 November 2008, for the first time, the Guidelines of ASRM were published.

The Association has a Practice Committee that issues regular reports, including guidelines on minimal standards for providing ART, informed consent and the numbers of embryos to be transferred in IVF technique[123], although these are not enforced by law.

In conclusion the US government decision is not to systematically issue all the fertility treatments but has passed secondary laws regarding activities linked to assisted reproduction technologies, such as laws regarding the human cloning (the federal law "*Prohibits the Secretary from using any funds for the conduct or support of human cloning*."[124]. There is no a law which bans human cloning completely, however there are several laws at state level, most of all banning that[125]).

3. STATE REGULATIONS ABOUT FERTILITY TREATMENTS AND SURROGACY

In order to gain an understanding of the US situation it is necessary to look at individual State regulations in assisted reproduction techniques, in particular heterologous fertilisation and surrogacy.

As already noted, each State can regulate fertility procedures however, they must be in compliance with Federal laws.

123 https://www.asrm.org/Guidelines/

124 H.R. 4808 (111th): Stem Cell Research Advancement Act of 2009 https://www.govtrack.us/congress/bills/111/hr4808#overview

125 http://www.ncsl.org/research/health/human-cloning-laws.aspx

In this study we will examine the two States of California and Massachusetts, even though after extensive research very little legislation can be found to have been enacted in these two States, as is true at the Federal level. Therefore this leaves US citizens more freedom in their reproductive procedural choices. In the absence of clear State regulations we must observe the protocol used in fertility centers to gain a clear understanding of the US situation.
ART legislation in the United States is therefore very different from that of the UK.

3.1 HETEROLOGOUS FERTILISATION: A COMPARISON OF TWO STATES

The Federal disciplines for sperm and egg donation are set out in Soft Law references and in the Guidelines for gamete and embryo donation of 2008 by ASRM.[126] These requirements are not binding for the clinics, but most of the medical centers in each State comply with them.
These ASRM recommendations underline the importance of psychological counselling for those who decide to proceed with donor insemination.
The Guidelines for sperm donation indicate the best qualities a donor should have, in particular they list:

- A donor should be in good health and without any known genetic abnormalities. A complete clinical examination is required to confirm all medical information[127]

126 http://www.npg-asrm.org/uploadedFiles/ASRM_Content/News_and_Publications/Practice_Guidelines/Guidelines_and_Minimum_Standards/2008_Guidelines_for_gamete%281%29.pdf

127 Id, 128

- *"The donor should be of legal age and, ideally, less than 40 years of age"*[128], after that age the risk of genetic diseases and foetus malformation increases.
- The ASRM also restricts donations based on the number of possible births by one sperm donor. This number is determined by the population of the geographical area concerned. "*It has been suggested that in a population of 800,000, limiting a single donor to no more than 25 births".*[129]

This last point is extremely important for the ASRM to avoid incestuous relationships between children born from the same sperm giver. A donor identity system, that allows easy and safe research for possible blood relationships, already existed before the publication of any Guidelines. This system provides a donor identity number and in doing so allows for the safe and easy research of potential blood relations.

The Guidelines also ruled on oocyte donation which involves significant inconvenience, discomfort and risk for the donor, unlike sperm donation. For these reasons the Guidelines underline the importance of a psychological consultation for donors and appropriate age limits. The provisions for egg donors are:

- "*Oocyte donors should be of legal age and preferably between the ages of 21 and 34 years"*, because donors under 21 years of age do not have the psychological stability to make a decision to donate. The donation should be based on

128 Id, 129

129 Id, 130

individual or altruistic reasons, and not on other interests such as money.[130]

- Monetary compensation to donors are allowed, but not in an amount to make it the only reason to push the donor to donate. *"Monetary compensation of the donor should reflect the time, inconvenience, and physical and emotional demands and risks associated with oocyte donation and should be at a level that minimizes the possibility of undue inducement of donors and the suggestion that payment is for the oocytes themselves"*.

Generally, the guidance states that any donor must sign a form in which he/she confirms his/her medical and genetic history. The information about his/her person must be kept on record in the clinics for at least ten years. Clinics must be immediately informed of any changes in health or risk factor status.

Clinics can choose to accept known donors and/or anonymous donations, what is important is the agreement of all parties concerned. It is important to note that both kinds of donors are absolved of all legal responsibility for children born from their donation, unless otherwise specified by the parties.

Finally, people looking for a donor are encouraged to choose the characteristics they desire him/her to have. However, if an error occurs in the implantation of gametes the case cannot be taken to court nor the responsible party sued for damages, excluding that this does not injure the child.[131]

130 Id, 131

131 This consideration is doing, taking into account the case decided by the Supreme Court of Utah: *David Harnicher v. University of Utah Medical Center* No.960204, 962 P.2d 67, 68 (Utah, 1998)

3.1.1 CALIFORNIA

In fertility clinics in the State of California, reproductive medicine is open to anyone who has infertility or other problems having a baby. Those who are married, in a relationship or single can be admitted for treatments. It is indifferent if they are heterosexual, homosexual or transgender. These procedures are decided on the basis of the necessity of the patient.[132]

3.1.1.1 GAMETE AND EMBRYO DONATION

Heterologous fertilisation means the use of one or both gametes from donors. Gamete donation involves the provision of gametes by a man or woman who is not intended to be the resulting child's legal parent. The California banks of gametes follow guidelines suggested by the ASRM, but some clinics establish their own rules and apply these in their centers.

The Federal guidelines on a donor's age are followed by the majority of clinics. As a matter of fact due to the high number of sperm donors, the age range for a giver is restricted to a younger age group[133]. There are often other requirements such as the need for a college degree, university graduation or even height specifications.[134] These exclude essential medical requirements.

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132 You can see it in some clinics website such as:
http://www.pacificfertilitycenter.com/treatment-care/lgbtq-care

133 See the Sperm Bank, Inc. of California. Here applicants must be between the ages of 18 and 28
http://www.spermbankcalifornia.com/donate-sperm.html

134 For example see: California Criobank requirements are Enrolled in (or a degree from) a 4-year university height of 5'9" and Enrolled in (or a degree from) a 4-year university.
The Sperm Bank of California asks a height of 5'7" and have completed or are pursuing a college degree

The ASRM guidelines limitation on the number of births per donor are not enforced by law and therefore not always respected.

Some sperm banks do however impose a more restrictive limit, such as the Sperm Bank of California that has a limit of ten families per donor.

The donor agencies for egg donations have age limit restrictions for givers, approximately thirty years of age.

In California the gametes banks support and promote the idea of donor payment. They specify that money should not be the motivation behind a donation, however this aspect is always advertised.[135]

The profit for sperm donors can vary depending on the agency, getting from $65 to $100 (U.S.D.).

The compensation for women who donate amount ranges from $5,000 to $10,000 (U.S.D.).[136] In addition, if they agree to travel to donate all related expenses are paid by the recipients. Of course a prior agreement regarding payment must be reached by all parties.

Evidence of deviations from the ASRM guidelines can be found in the newspapers, much higher prices are offered to “special donors” with particular physical or intellectual characteristics. In March 2000, an ad appeared in «The Daily Californian» (the Campus newspaper for the University of California, Berkeley) which read, “Special Egg Donor Needed” and listed preferred donor criteria. The compensation was $80,000 for a selected donor. In addition, all related expenses were to be paid.[137] Although a database of these

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135 For example the California Cryobank seems to transform the sperm donation in a job, saying “Be your own boss - Donate at your convenience up to 3 times a week ($125.00/donation)”; and also “Note that sperm donors are required to report their earnings for tax purposes”.

136 ASRM states: “Although there is no consensus on the precise payment that oocyte donors should receive, at this time sums of $5,000 or more require justification and sums above $10,000 go beyond what is appropriate.”

137 Debora L. Spar. 2006, The Baby Business: How Money, Science and Politics

advertisements does not exist, ads promising hundreds of thousand of dollars usually only appear in college newspapers.

A study, made by Aaron Levine[138], of ads for egg donors, underlines that the existence of an advertisement does not mean that the money was actually exchanged.

The study reveals that:

> *The possibility exists that some advertisements offering high compensation are not genuine offers, but rather a ploy to build an agency's list of potential donors using a "bait and switch" tactic. This idea gains some credence from the lack of highly compensated donors appearing in follow-up studies of oocyte donors*[139]*. In at least a few cases, however, employees of donor agencies have confirmed that sums as large as $35,000 or $50,000 have been paid. Even if compensation of $20,000, $35,000, or $50,000 (all levels seen in the sample of oocyte donor recruitment advertisements reported here) represent the fringes of the "market" for oocyte donation and occur only infrequently.*

The prospective parents choose donors in the hope of providing their offspring with certain inheritable traits. This is often an attempt to design one's children, something many people find unsettling.

Those who oppose embryo selection and the selection of a donor with particular traits and the exchange of large sums of money for

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Drive the Commerce of Conception, Boston: Harvard Business School Press.

138 Aaron D. Levine, "Self Regulation Compensation and the Ethical Recruitment of Oocyte Donors" ,Hastings Center Report40, no. 2 (2010): 25-36

139 A.L. Kalfoglou and J. Gittelsohn, "A Qualitative Follow-Up Study of Women's Experiences with Oocyte Donation," Human Reproduction15, no. 4 (2000): 798-805; N.J. Kenney and M.L. McGowan, "Looking Back: Egg Donors' Retrospective Evaluations of Their Motivations, Expectations, and Experiences during Their First Donation Cycle," Fertility and Sterility 93, no. 2 (2010): 455 66.

this practice, maintain that these parents could have the wrong parental attitude and this could be harmful to children.

Prospective parents should want to have a child to love and not focus on the characteristics they desire in a baby. It is one thing to want a healthy child and quite another to be willing to pay huge sums to get a "super baby". A parent is supposed to love his children just because they are his children. It is also possible that the children may not be born with these desired traits. What would happen if a parent spent a lot of money but the child does not meet their expectations? And what would be the impact on the relationship between parent and child?

These choices to design a baby are perhaps even more relevant when speaking of embryo donation.

This type of donation can involve two types of procedures: the creation of an embryo using donated gametes or the donation by a couple of surplus embryos, from a prior fertility treatment.

In both cases the donors must sign a consent form giving permission to use their gametes or embryos. The ASRM guidance also explains the importance of psychological support for this type of decision.

Under the Provision of the California Penal Code at Section 367g[140] anyone who knowingly uses sperm, ova, or embryos in assisted reproduction technology, for any purpose other than what it is indicated by the donors in the consent form shall be punished by imprisonment (three, four, or five years) or by maximum fine of fifty thousand dollars, or both.

Donors are not paid for the embryo donation but reimbursed by the recipient for specific expenses related to the donation. These expenses may include testing and screening (e.g.; obligatory blood tests) as well as expenses incurred transferring the embryos to the

140 Available at: http://www.leginfo.ca.gov/cgi-bin/displaycode?section=pen&group=00001-01000&file=346-367g

clinic and costs for thawing the embryo. The State of California prohibits embryos from being acquired, sold or offered for sale.[141]

Usually the donated embryos undergo freezing for future research or implantation for reproductive purposes. There is no limit for the maximum storage period of embryos. The cryopreservation payment procedure does not have a time limit either, it only sets price schedules for short and long periods.

The Procedures for human embryo freezing were developed in 1984 and widespread use began in the late 1980s. This means that the longest time a human embryo has been stored is 25-30 years and patients with embryos in storage for this long have not returned to use them. Some patients have returned after 10-12 years and the embryos have been thawed successfully and healthy babies born.

A formal written request from both parties is required to destroy the frozen embryos. When the clinic receives the request, it gives the applicants some time for reflection. At the conclusion of this period the embryos are then thawed and discarded.[142] If payment of storage is not met, or one of the donors dies the same solution is applied.[143]

The California Health and Safety Codes at Section 125315[144] require that healthcare providers give infertility patients the necessary information to make informed choices regarding availability of their

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141 Senate Bill No. 1260 CHAPTER 483; SB1260, Ortiz. Reproductive health and research. Available at: http://www.cdph.ca.gov/services/boards/HSCR/Documents/MO-SB1260-08-2007.pdf

142 The Pacific Fertility Center have a period of waiting before destroy the embryos of 30 days;

143 See for example Sperm Bank, Inc dba Fertility Center of California www.spermbankcalifornia.com 6699 Alvarado Rd #220812791 Newport Ave., #206 San Diego, Ca. 92120 Tustin, Ca. 92780 Tel:619-265-0102 Fax:619-265-1429 Tel:714-730-3060 Fax:714-730-3063Reproductive Material Cryostorage Agreement

144 http://www.leginfo.ca.gov/cgi-bin/displaycode?section=hsc&group=125001-126000&file=125300-125320

frozen embryos. The patients also have the right to set out directives for the disposition of frozen embryos.

CPC Section 6407[145] of California law recognizes the rights of posthumously conceived children to inherit. This law states that a child conceived with a deceased person prior to their death, is entitled to inherit. The application of this provision to embryos resulting from fertility treatment, is detailed under CPC Section 249.5[146]. The Code states when a child is conceived after the death of a decedent, it may be deemed to have been born during the decedent's lifetime and after the execution of all of the decedent's testamentary materials. Written evidence must exist confirming the decedent's willingness to provide his or her genetic material for the posthumous conception of a child. The rule provides that gametes may only be used for a two year time period after death.

3.1.1.2 MULTIPLE BIRTH PREGNANCIES

On 26 January 2009, in Bellflower, California, Nadya Suleman made history by giving birth to the first surviving octuplets.[147] Doctor Michael Kamrava, who performed all of Nadya's IVF treatments, had implanted her with twelve embryos at once, as per her request. The number was well above the American Society for Reproductive Medicine's recommendation[148].

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145 Available at: http://www.leginfo.ca.gov/cgi-bin/displaycode?section=prob&group=06001-07000&file=6400-6414

146 Available at: http://www.leginfo.ca.gov/cgi-bin/displaycode?section=prob&group=00001-01000&file=248-249.8

147 http://news.bbc.co.uk/2/hi/americas/7852623.stm.

148 Citing ASRM "G*uidelines on number of embryos transferred*", 2004. *"For patients under the age of 35 who have a more favorable prognosis, consideration should be given to transferring only a single embryo . No more than two embryos (cleavage stage or blastocyst) should be transferred."*

The case was very controversial because the woman was 33 years old, unemployed and single. She already had six children conceived with IVF with the same fertility doctor, including twins and an autistic son.[149]

Doctor Kamrava was subject to an investigation by the Medical Board of California for *"a violation of the standard of care"* due to his decisions concerning his patient Nadya.

He was expelled and his medical license was revoke for five years from 1 July 2011. The Medical Board founded its decision on repeated negligent acts by the physician on three documented patient cases.[150]

The Octuplet birth "drama" brought ART and the problem of multiple birth pregnancies to national attention once again. Multiple birth pregnancies can create serious medical and psychological risks to both the mother and children conceived using IVF. The subject was examined by all States, but no new laws to decrease multiple pregnancies were adopted by any State, including California.[151]

Guidelines for the number of embryos to be transferred in-vitro fertilization cycles were published in Fertility and Sterility by the Practice Committee of the ASRM in cooperation with SART Committee.[152]

Available at: http://www.fertstert.org/article/S0015-0282%2809%2903625-5/fulltext

149 http://www.bionews.org.uk/page_13675.asp

150 Decision of the Medical Board of California on Michael Kamrava 's medical license (June 1, 2011), Agency case No. 06-2009-197098.
Available at: http://documents.latimes.com/michael-kamrava-disciplinary-decision/

151 In Georgia the State Senate propose a bill entitled the *"Ethical Treatment of Human Embryos Act"*, but this was never turn into law.
A bill proposal was made in Missouri, to enforce fertility clinics to respect the limit established by ASRM in embryo implantation. That bill was not voted by the State government.

152 Fertility and Sterility Vol. 99, No. 1, January 2013 0015-0282, 2013 American Society for Reproductive Medicine, Published by Elsevier Inc.

The ASRM gives specific criteria about the numbers of embryos which can be implanted in a woman, based on her age:

> A) *Patients under the age of 35 who have a favorable prognosis should be offered a single-embryo transfer and no more than two embryos (cleavage stage or blastocyst) should be transferred. If two embryos are transferred, the patient(s) must be counseled regarding the risks of multifetal pregnancy and the counseling should be documented in the patient's permanent medical record.*
>
> B) *For patients between 35 and 37 years of age who have a favorable prognosis, no more than two cleavage- stage embryos should be transferred. All others in this age group should have no more than three cleavage-stage embryos transferred. If extended culture is performed, no more than two blastocysts should be transferred to women in this age group.*
>
> C) *For patients between 38 and 40 years of age who have a favorable prognosis, no more than three cleavage- stage embryos or two blastocysts should be transferred. All others in this age group should have no more than four cleavage-stage embryos or three blastocysts transferred*
>
> D) *For patients 41 42 years of age, no more than five cleavage-stage embryos or three blastocysts should be transferred*

It also recommends that physicians consider a patient's previous success with IVF, the quality of the embryos to be transferred, and whether the excess embryos are eligible for cryopreservation.

Available at: http://www.asrm.org/uploadedFiles/ASRM_Content/News_and_Publications/Practice_Guidelines/Guidelines_and_Minimum_Standards/Guidelines_on_number_of_embryos%281%29.pdf

In CDC National Vital Statistic report 2013[153], published in January 2015, we can find a decrease in multiple births (in reference to births of three children from the same mother) in recent years. This could be as a result of the new ASRM instructions.

The CDC data shows that, with the growth in use of ART, in the 80's, the numbers of multiple births have increased by 400%, however this has had a downward trend in recent years.

The Statutes of Business and Professions Code Business Sections, 2505 - 2521[154] is the only Code in the State of California, which has specific references to multiple births. It requires midwife staff to report to the Office of Statewide Health Planning and Development the particular childbirth circumstances in which they assist. Multiple births are one of these.

It is possible to conclude from this that multiple childbirths are a common occurrence in this State. In support of this we can find many specialists for multiple births[155] and support program for the families.

3.1.1.3 QUESTION OF PARENTHOOD

Legal parenthood can be defined as possessing the legal parental rights and responsibilities for a child.

153 Joyce A. Martin, M.P.H.; Brady E. Hamilton, Ph. D; Michelle J.K. Osterman, M.H.S.; Sally C. Curtin, M.A.; T. J. Mathews, M.S., Division of Vital Statistics; National Vital Statistics Reports, Vol.64, No.1, January 15, 2015, at 11. Available at: http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_01.pdf

154 Business and Professions Code Business Section 2016 (a) (3) (I) (ii)

155 Some of whom are : Gill, Pamela J. Coordinator of the Preterm Birth Prevention Program Children's Hospital of San Francisco; GOETZMAN, Boyd W., Professor of Pediatrics Division of Neonatology Department of Pediatrics School of Medicine Univ. of California, Davis, CA; GOLDHABER, Marilyn K., Perinatal Epidemiologist Berkeley, CA; KATZ, Michael, Maternal-Fetal Specialist Univ. of California San Francisco, CA.

In the US, a pregnant woman's husband is usually presumed to be the child's legal father. Marriage, not biology determines the legal parental relationship.[156]

In States such as California where different sex and same sex couples can marry, members of same sex unions benefit from this marital presumption in the same way that heterologous married couples do.[157]

Since 1 January 2005 in California the law states that when a child is born the registered domestic partners are the child's parents.

The rise of ART has prompted many questions regarding assignment of legal parenthood. New laws have been enacted to legitimize petitioning parents in becoming the legal parents of children born from assisted reproduction and to clarify the parental status of donors.

Each state's approach to questions on parenthood reflects whether they support biology, intent, marriage or a contractual agreement as the basis for starting a family.

The Uniform Law Commission has attempted to develop an uniform parenthood legislation through the 2002 Uniform Parentage Act (UPA)[158]. The application of the standards is not enforceable by law. Each individual state is free to implement this Act. The majority have adopted it.[159]

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156 This " marital presumption" is a Common Law presumption, and it is also affirm in the Uniform Parentage Act (UPA) at Section 2.

157 California Transgender Family Law. Available at: http://www.nclrights.org/wp-content/uploads/2013/07/Transgender_Family_Law_CA.pdf

158 Available at: http://www.uniformlaws.org/shared/docs/parentage/upa_final_2002.pdf

159 See the enacted status maps at http://www.uniformlaws.org/Act.aspx?title=Parentage%20Act

The UPA established that an egg or sperm donor[160] is not the parent of a child when conceived through ART. Parental status can only be assigned when there was been a normal sexual relationship with the requested parents.[161]

In California the presence of a doctor is required in the insemination program and this is what determines the donor and the donor-conceived offspring's parenthood. The donor is excluded from a parenthood relationship if it is specified in the donation agreement between the parties or if a clinic or fertility bank is used, as is shown by *Jhordan C. v. Mark K. (1986)*[162] case law.

In this case the court allowed a claim of paternity by the man who had provided semen to inseminate a friend. The CA Court of Appeal explains that by California Civil Code:

> "*a donor of semen provided to a licensed physician for use in artificial insemination of a woman other than the donor's wife is treated in law as if he were not the natural father of a child thereby conceived.*"[163]

The woman performed the insemination at home. She could not deny Jhordan C. legal rights to the baby because they did not draft a written agreement concerning Jhordan's status, and they were not

160 The comment to the *Uniform Parentage Act*, Section 702 says that: "donors are eliminated from the parental equation"

161 *Uniform Parentage Act, Section* 202(4), 702.:
"Assisted reproduction" means a method of causing pregnancy other than sexual intercourse. The term includes:
(A) intrauterine insemination;
(B) donation of eggs;
(C) donation of embryos;
(D) in-vitro fertilization and transfer of embryos; and
(E) intracytoplasmic sperm injection

162 *Jhordan C. v. Mark K. (*1986), 179 Cal.App.3d 386.Available at: http://law.justia.com/cases/california/court-of-appeal/3d/179/386.html

163 California Civ. Code, § 7005.

aware of the existence of Section 7005 of the Civil Code. The only possibility to rule out a parenthood claim by a donor is if the semen is provided to a licensed physician for insemination.

The case of: S*teven v. Deborah (2005)*[164] also confirms this provision.

Here the California Appellate Court maintained that the sperm provider was a donor with no parental status because the child was conceived by artificial insemination performed by a physician. The Court applied the Family Code section 7613, subdivision (b).

Deborah and Steven, who were not married, went to a physician to artificially inseminate Deborah with Steven's sperm. The cycle of fertility treatment did not give the desired result and Deborah's pregnancy did not go full term. Steven and Deborah then had normal sexual intercourse over a period of month with no resulting pregnancy. Shortly after the end of this sexual relationship, Deborah tried to conceive again through artificial insemination using Steven's sperm originally provided for that purpose. Deborah became pregnant and this time gave birth to a son, Trevor.

The donor argued that he and the mother had attempted to conceive through sexual intercourse prior to this insemination. Deborah argued that conception occurred through the last artificial insemination procedure.

The court concluded that the fact a physician was involved in the treatment to conceive, the donor's potential rights as the father were inapplicable.

The court could have provided a different ruling for Steven if a written agreement had been made before the donation, requesting that he be considered as the child's legal father. In fact this is an exception to what is stated in Section 7613. If prior to conception the

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164 *Steven v. Deborah,* March 3, 2005; Court of Appeal, Second District, Division 4, California. Available at: http://caselaw.findlaw.com/ca-court-of-appeal/1258465.html#footnote_1

donor and recipient have declared in writing, that they both intend for the donor to be the father, he will be treated by law as the father and not the donor. Therefore this provision states that a man who provides his sperm directly to a woman also with the assistance of a medical clinic can be the father.

The decision to use a known donor often further complicates the issue of parenthood. It can mean that both the donor and the recipient are to be included in the child's life. What is important is for all the parties involved to come to an agreement and to adhere to the laws of the State.

The first step for the parties to make a known donor arrangement is to determine exactly what the role of the direct donor will be in the child's life, for example the amount of contact he/she will have with the baby, as well as the legal standing the donor will have with the child.

In the absence of legislation case law also plays a crucial role on same-sex parental rights.

A recent California case has created extrinsic rules to establish parentage: *K.M. v. E.G*, 37 Cal. 4Th 130, 144 (Cal. 2005).[165]

During her same sex relationship with K.M, E.G, a woman who had been trying for years to get pregnant, was visited by Doctor Mary Martin at the fertility practice of the University of California at San Francisco Medical Center (UCSF). After the first failed IVF cycle, the doctor suggested to use her partner's ova.

E.G. then asked her partner K.M. to donate her ova, explaining that she would only accept if K.M. "*would really be a donor*" and E.G. would "*be the mother of any child*" born from the donation.

K.M. accepted to donate and she agreed not to disclose to anyone that she was the donor. However in court she insisted that she

165 *K.M .v. E.G*, 37 Cal. 4Th 130, 144 (Cal. 2005).Available at: https://casetext.com/case/km-v-eg-2

provided her ova on the understanding that she and E.G. had agreed to raise the child together. Both K.M. and E.G. also selected the sperm donor together.

Six years later after raising the twin girls for five years together, the women broke up and EG denied that KM was one of the legal parents of the children.

K.M. filed a petition to establish her parental rights over the twins.

The clinic consent forms, signed by K.M. showed that she was only an egg donor and not the parent of the baby conceived using her eggs. In fact K.M. had signed the donor consent in which she declared that no parental right would be claimed by her if any children were born from her donation. So the California Court of Appeal denied her petition.

The Court of Appeal ruled that Sections 7613(b) and 7650 of the California Family Code applied in the case of K.M.[166]. The court determined that Section 7613(b) should be implemented in a situation involving an egg donation to an unmarried woman regardless of the existence of a lesbian relationship.[167]

K.M. took her appeal to the California Supreme Court and the Court of Appeal ruling was reversed. The Supreme Court did not confirm the rationales of both lower courts, concluding that Section 7613(b) did not apply in K.M. v. E.G. because it was not a true egg donation.

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166 Section 7613(b) states: "The donor of semen provided to a licensed physician and surgeon for use in artificial insemination of a woman other than the donor's wife is treated in law as if he were not the natural father of a child thereby conceived." CAL. FAM. CODE § 7613(b) (West 2005). Section 7650 states that insofar as I practicable, the provisions applicable to a father and child relationship should determine a mother and child relationship. CAL. FAM. CODE § 7650 (West 2005)

167 K.M., 117 P.3d at 675, 681. The California Supreme Court concluded that section 7613(b) does not apply when a lesbian provides her ova to impregnate her partner and they raise the children in a joint home. The court specified that both the woman who provides her ova and her partner who bears the children are the children's parents.

The Supreme Court underlined that what needed to be taken into account was not K.M's intention to be a mother but the fact that the couple lived together and intended to bring the child into their joint home. This fact was sufficient to establish K.M.'s parental relationship.

According to the ruling on the *K.M. case*, a lesbian woman who donates ova to her partner and intends to raise the resulting child in a joint home with the gestational mother is legally considered to be a second mother to the child. The law applies even if the lesbian couple has clearly declared that only the gestational mother will be the single legal parent.

The most recent and significant provision in the State of California regarding parentage legal status, was approved in October 2013[168] when Sections of the CA Family Code were amended. The innovation of this law was the provision to allow three people to be the legal parents of a child.

> *"This bill would authorize a court to find that more than 2 persons with a claim to parentage, as specified, are parents if the court finds that recognizing only 2 parents would be detrimental to the child. The bill would direct the court, in making this determination, to consider all relevant factors, including, but not limited to, the harm of removing the child from a stable placement with a parent who has fulfilled the child's physical needs and the child's psychological needs for care and affection, and who has assumed that role for a substantial period of time."*

168 Senate Bill No. 274; Chapter 564; Family law: parentage: child custody and support. Available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140SB274

The three parenthood law can also be applied to the rights of a gamete provider and that of surrogates.

Before the publication of the law there was a case, *In Re M.C.*[169], in which the California Court of Appeal ruled in a situation of serious family difficulties. Here the court cleared three parents for baby M.C. (two mothers: Melissa the biological mother and Irene, her wife; one father: Jesus, the biological father). This ruling was most probably the reason for the drafting of that law.

3.1.2 MASSACHUSETTS

Massachusetts was the first State involved in the CDC SMART project. Massachusetts created a special form to register information about mothers and babies born in that State.[170] The aim of this program was to study and to better understand the impact of ART on infant and maternal health.

The most recent data collected by these monitoring activities[171], shows only 8% of the woman interviewed had used some form of assistance to get pregnant, approximately half of this number resorted to Assisted Reproduction Technologies.

The development of ART in this State is significant. Massachusetts has 42 fertility specialists and requires insurance companies to reimburse some fertility treatments. These statistics are provided by the Resolve[172] organisation's survey completed last year. It found an

169 *In Re M.C.*195 Cal.App.4th 197 (2011). The decision of the case is available at: http://law.justia.com/cases/california/court-of-appeal/2011/b222241/

170 Massachusetts Pregnancy Risk Assessment Monitoring System (PRAMS)

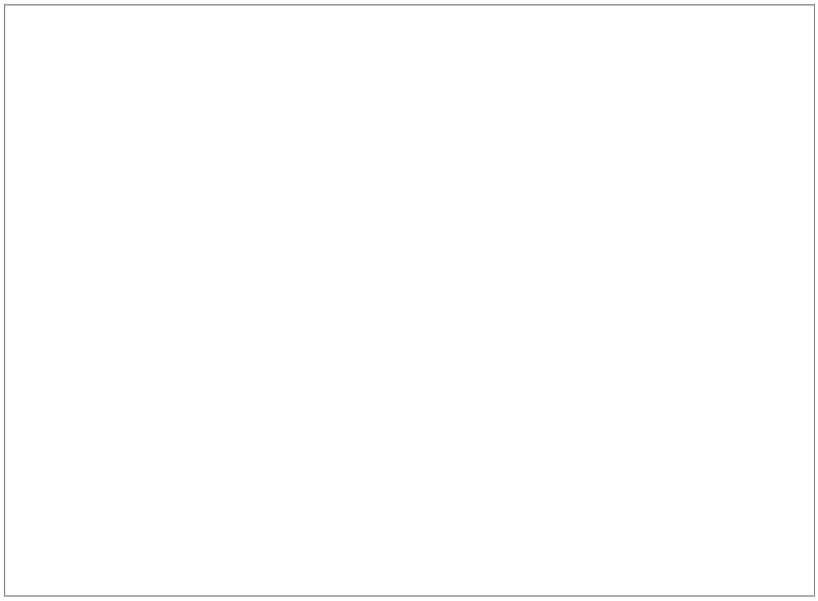
171 PRAMS record is available at Massachusetts Health and Human Service website, at: http://www.mass.gov/eohhs/gov/departments/dph/programs/family-health/pregnancy-risk-assessment-monitoring-system.html

172 RESOLVE is a no-profit organization, who works to improve the lives of women and men living with infertility. Resolve.org is the official website.

increase in the fertility services across the country. Resolve assigned classifications based on these parameters:

- *Number of physicians specializing in infertility in state, at SART-accredited fertility clinics*
- *Number of peer-led RESOLVE support groups in state for people experiencing fertility issues*
- *Number of women in state who have experienced physical difficulty in getting pregnant or carrying a pregnancy to live birth*
- *Insurance mandate information in each state*[173]

Massachusetts turns out to be one of five states nationally to receive an 'A' for fertility resources, while California has a 'B'.



The figure shown the Massachusetts status identified by RESOLVE.

173 http://familybuilding.resolve.org/fertility-scorecard/

3.1.2.1 GAMETE AND EMBRYO DONATION

The provisions for gametes donation in Massachusetts are similar to Californians. Massachusetts clinics follow the ASRM Guidelines very strictly.

The clinics requirements for egg and sperm donations are almost the same as those in California clinics and banks. Payment as in California for egg donation has the same range from $5,000/$10,000 (U.S.D.). Documentation available shows that sperm donors also appear to have similar payment fees; a sperm donor can receive up to $100[174]/$125[175] (U.S.D.).

There is more regulation in Massachusetts on embryo donation due to both law and court cases regarding this question.

Chapter 112 of the Mass. General Law prohibits the use of any live human foetus or embryo before or after expulsion from the mother's womb for scientific and laboratory research or other experimentation.[176] Only embryos or foetuses that have been implanted in the woman's womb with a resulting pregnancy can be subject to that law.

The State has enacted a specific law regarding embryo and human cloning: General Law, Chapter 111L, Section 8.

The provision bans reproductive human cloning and punishes persons who knowingly *"sell, transfer or otherwise obtain human embryonic, gametic or cadaveric tissue for the purpose of human reproductive cloning"*. Those who do not respect these rules face imprisonment of up to ten years or a fine of up to $1,000,000

174 New England Cryogenic Center; http://www.necryogenic.com/become-a-donor.php

175 California Cryobank branch; http://www.spermbank.com/why-donate/sperm-donor-pay

176 General Laws, Part I, Title XVI, Chapter112, Section12J

(U.S.D.).[177] However therapeutic cloning is permitted for purposes of research, but only after written consent from an institutional review board.

The Massachusetts Supreme Judicature Court ruled on a case of cryopreservation of embryos and consensus of use: *A.Z. v. B.Z.*[178]

B.Z. (wife) and A.Z. (husband) sought treatment at an IVF clinic over several years. Some embryos resulting from the procedures were frozen with the couple's consent. The dispute over the frozen pre-embryos arose when the father, in the course of divorce proceedings learned of the will of his former wife from his insurance company. She wanted to implant them and he consequently filed for an injunction preventing her from doing so, as it was against his wishes.

The wife opposed A.Z. and based her request on the initial agreement between the parties.

The court ruled that the agreement was not enforceable because of the *"change in circumstances"*, which could not have been taken into account previously. The decision was also a question of public policy: a *"forced procreation"* is not possible. It means frozen embryos can never be implanted if the father withdraws consent, even if the mother proves a different agreement between the parties had been made earlier.

The ruling of the court leaves the frozen pre-embryo agreement in limbo. The value of these consent forms depends on the will of the parties but if there are any changes in their personal situations, they are not enforceable by law. The future of the embryos is limited to the future of the parents' relationship, an unknown quantity.

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177 General Laws, Part I, Title XVI, Chapter 111L, Section8

178 Available at: http://caselaw.findlaw.com/ma-supreme-judicial-court/1470341.html

3.1.2.2 QUESTION OF PARENTHOOD

The Uniform Parentage Act (2002) ensures married couples that use ART for giving birth, that they are the legal parents of the child born. No rights are reserved to the donor. This Act is also enacted in Massachusetts.

The woman who gives birth to the child is the legal mother even if the ova came from a donor, and her husband is the father.

If a sperm donor is anonymous and does not want to be involved in the conceived children's life, the husband of the mother is considered to be the legal father under the Common law marital presumption.

In this State as in California, case law is used as the basis for regulation. The laws regarding relationships between donors, recipients and conceived offspring cover specific arguments.

In a historic decision, *Goodridge v. Department of Public Health*[179], the Massachusetts Supreme Judicial Court on 18 November 2003, ruled the end of the exclusion of same-sex couples from marriage in Massachusetts.

It was significant because it was the first of its kind in this country by a State high court. Gay and lesbian families and their children were finally allowed to have equal rights as families. It meant that, in Massachusetts a child born to a married couple is presumed to be the child of both members of the couple independently of their homosexuality or heterosexuality. This provision only has effect if the same sex parents are married, if they are not married children born in those families have just one parent registered on the birth certificate. The other, non biological parent, must adopt the child if he/she wants to be the second legal parent.

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179 *Hillary Goodridge & others vs. department of public health & another*, 440 Mass. 309, 798 N.E.2d 941 (2004).

What is the fatherhood of these non-marital children? The Massachusetts law states that if a man who is not the biological father, or is the donor of conceived children through ART is in agreement with the mother and wants to be the legal parent of the offspring, he can sign the "voluntary acknowledgement of parentage[180]" form.

This is a legal document which can be completed before the child's birth, and has the same value as a court judgement. It must be filed with the child's birth certificate and the names of both parents will be on that certificate. If any new situation regarding the parenthood emerges the father has 60 days after signing the form to revoke the acknowledgment. Within a year he must file a lawsuit in the probate and family court if there is fraud, duress or material mistake of fact. The court must order genetic tests and proceed to determine paternity as in a contested case. If the court revokes the paternity, it must instruct the Registry of Vital Records to amend the birth record of the child.

Any agreement between the parties who are in relation with the baby and are known donors, is not recognized in the State of Massachusetts as it is in California.

A sentence of the Massachusetts Supreme Court of 2004[181] ruled that *"parenthood by contract"* is not allowed by State law and is against public policy. An agreement of any type which requires people to become a parent through a contract, if taken to court is not enforceable. So we can assume that any other kind of contractual arrangement, which enforces the relationship between children and a third person is not achievable by law. In fact clinics in this part of the Country only reveal the person who is the known donor to the

180 The form is available at: http://www.mass.gov/dor/docs/cse/parents/voluntary-ack-of-parentage-form.pdf

181 *T.F. v. B.L.* Supreme Judicial Court of Massachusetts442 Mass. 522,

conceived child, if he/she requests this information once reaching eighteen years of age. Unlike California where the family and donor relationship with the conceived child is much more open.

3.1.2.3 POSTHUMOUS REPRODUCTION

The Uniform Parentage Act regulates the situation of posthumous reproduction through ART. The Act provides that if a person consents to become a parent through assisted reproduction, but dies before the placement of gametes or embryos, he/she will not be considered as a parent of any child resulting from the procedure unless a record exists of his or her will to do so.[182] This acknowledgement opens the possibility for the posthumous offspring to inherit.

Few States including California,[183] explicitly regulate the possibility for children born and conceived after the death of their parent to inherit. However Massachusetts is not one of these States and has a specific position on this subject resulting from a decision of the Supreme Court of Massachusetts. This ruling denies the recognition of a gamete donor as the parent of a posthumously conceived child as certain requirements were not met.

The case was *Woodward v. Commissioner of Social Security, 435 Mass. 536 (2002)*[184].

James Woodward married the appellant, Lauren in 1993. Three years later, Mr. Woodward learned that he had leukemia and was advised that the treatment may have left him sterile. Therefore he decided to preserve a quantity of his semen in a sperm bank. Unfortunately he died later that year. Two years after his death in 1995, the wife gave birth to twin girls. The children were conceived through artificial

182 Uniform Parentage Act (2000) §707 (Revised 2002).

183 Other State are Colorado, Delaware, Florida, Texas, North Dakota, Virginia, Wyoming and Washington.

184 *Woodward v. Commissioner of Social Security*, 435 Mass. 536 (2002)

insemination using the husband's preserved semen. In January, 1996, the wife applied for two forms of Social Security survivor benefits for her children and her. The Social Security Administration rejected Mrs. Woodward requests. The administrative judge reasoned that the children were not "*ascertainable heirs as defined by the intestacy laws of Massachusetts*" because they were neither born nor in utero at the date of the husband's death and "*the statutes and cases contemplated an ascertainable child, one who had been conceived prior to the father's death*". He also found that the children could not inherit under Massachusetts intestacy law because the evidence failed to establish that the husband, before his death neither acknowledged the children as his own nor intended to contribute to their support.[185]

After she demonstrated that the twins were the children of her dead husband, Ms. Woodward requested the federal District Court to release the benefits. That Court asked the Massachusetts Supreme Judicial Court to rule on the legal question. The Massachusetts Supreme Court found that such inheritance rights exist, but only under certain limited circumstances.

These requirements include: the gamete provider's written consent for posthumous reproduction before his death. The donor must agree to support any resulting child and his genetic relationship must be established. When these requirements have been met and the birth occurs within a reasonable time period, the Massachusetts court legally recognizes the parenthood relationship.

Once the genetic relationship with the offspring is identified, the children's right to inherit is inevitable.

3.2 SURROGACY

185 Massachusetts General Laws, chapter 190,§8

Surrogate maternity, more than any other assisted reproduction techniques, raises controversial debates, and legislation concerning surrogacy is differently in each State.

Two types of surrogacy are recognized in the USA: traditional surrogacy, in which the mother has a genetic relationship to the child growing inside her, so she is not only a carrier of the baby; and genetic surrogacy, in which the surrogate mother is not genetically related to the child, an unrelated embryo is implanted in her, she is just a carrier.

The text is looking at the approach to these techniques focusing on the States of California and Massachusetts.

Before moving on to the individual characteristics that distinguish these States, it is possible to have a look at what they have in common.

Both allowed the use of surrogacy, on commercial basis, and fertility clinics are available throughout the two Sates which provide the procedure.

Singles, married, unmarried couples of any sexual orientation can have access to the treatment.

The payment of the surrogate is allowed and it is outline in the surrogacy arrangement. The average amount paid to a surrogate mother is around $35.000 (U.S.D). Compared to the cost of hundreds of thousands of dollars the intended parents afford for all surrogacy procedure is a small price. The fertility clinics suggest an approximate sum of money to pay for the commissioning parents. Cost includes expenses for different needs, the price changes depending on the numbers of gametes received. The clinics also suggest the possible costs that the carrier might incur during her pregnancy, such as psychological support, drugs and clinics visits, clothing etc.

There are situations that can drive up costs, for example a multiple birth or a Caesarean.

Thus, we can say that the possibility of access to the treatment is not for everybody, it is only for the wealthiest.

3.2.1 CALIFORNIA

California is probably the State which is more advanced in surrogacy, although has no statute that directly addresses the surrogacy procedure. The state's courts have used California's Uniform Parentage Act (UPA) as tool to interpret of different cases related to the new procedure.

In California was ruled one of the first, and more famous, case law on genetic surrogate maternity: *Johnson v. Carlvert.*[186]

Mark and Crispina Calvert were unable to have a child. Miss Anna Johnson, having heard of the Calverts' situation, offered to serve as a surrogate. So Miss Johnson was implanted with an embryo created using Mark's sperm and Crispina's eggs and the child born would be taken by the Calverts as their child.

In return for three payments of $10,000, the last to be paid six weeks after the child's birth, and a $200,000 life insurance policy, Anna agreed to renounce all parental rights to the child. Unfortunately the relationship between the two sides deteriorated during Anna's pregnancy.

Anna wrote, few months after the conception, to the spouses demanding the last payment, which should have been paid according

186 *Johnson v. Calvert (1993)* 5 Cal. 4th 84 (1993)
Available at:http://law.justia.com/cases/california/supreme-court/4th/5/84.html

to the agreement after the child's birth, otherwise she would not give up the baby.

The Calverts then, decided to go to court to ask for a declaration that they were the legal parents of the child; Johnson filed a petition to be recognized as the child's mother. The two cases were consolidated in front of the same court.

After the birth of the baby, in September, the trial court ordered a blood analysis to certify the biological relationship of the child with his genetic parents. The court affirmed that the genetic and natural parenthood belonged to the Calverts and denied Anna any right to the child and stated that the surrogacy agreement was legal and enforceable against her. Miss Johnson appealed up to the California Supreme Court.

The Supreme Court faced the difficulty of identifying the legal mother of a child who has both a birth mother and a genetic mother in two different people. The court used the interpretation of the Uniform Parentage Act and the California Civil code to solve the matter. The solution of the dilemma for the court was possible just looking at the intention of the parties involved in the surrogacy agreement. In fact for the UPA both the gestation and genetic ties can give rise to a presumption of parenthood, but in that case the two situations did not coincide, so the court explained:

> *"When the two means do not coincide in one woman, she who intended to procreate the child-that is, she who intended to bring about the birth of a child that she intended to raise as her own-is the natural mother under California law."*

In that case the Calverts' intention to create a family was the reason of the child's birth, so they are considered his/her legal parents. This also seemed to be the best choice for the child's life, a couple who

felt so strongly the desire so strongly to have their own family to create one with the help of another woman.
That was also the reason that urged the court to reject the Miss Johnson's arguments, brought to obtain the motherhood of the baby: she argued that the Calverts are simple gametes donors. The court stated that:

> *"...the facts is, however, inaccurate. Mark and Crispina never intended to "donate" genetic material to anyone. Rather, they intended to procreate a child genetically related to them by the only available means."*

In the end the court explains that surrogacy is a particular case for the application of UPA because here the will of the parties goes beyond the genetics and could not be explained just through the natural relationship between a pregnant woman and the child she carries in her womb:

> *"A woman who enters into a gestational surrogacy arrangement is not exercising her own right to make procreative choices; she is agreeing to provide a necessary and profoundly important service without (by definition) any expectation that she will raise the resulting child as her own."*

Another case of surrogacy, decided by the California Court of Appeal in 1994, was a case of traditional surrogacy, ended with the opposite ruling. The lawsuit was: *In re Marriage of Moschetta (1994)*[187].

187 *In re Marriage of Moschetta (1994)* 25 Cal.App.4th 1218 .Available at:http://law.justia.com/cases/california/court-of-appeal/4th/25/1218.html

The Moschetta spouse made an agreement with Elvira Jordan, the surrogate, to be inseminated with the sperm of Mr Robert Moschetta and to give birth to a child for the couple.

However, when the Moschettas broke up during her pregnancy, Elvira decided to keep the baby, although when the couple reconciled she relented and allowed the child to go home with them.

Once the couples broke up once and for all, Cynthia, the former Moschetta wife, asked the court to be recognized as the legal mother of the new born (Marissa), she based this request on the surrogacy agreement between Moschettas and Elvira Jordan.

The case found a different conclusion than the *Calvert's case*, because here Elvira was at the same time the genetic and gestational mother. The pre-birth arrangement between the parties in that case could not change the provision on parentage, the contrary would be against the public policy.

The Court held that the intended father and the surrogate mother were the legal parents of the child, leaving the intended mother without parental rights.

The solution ruled by the court makes us understand that different regulations must be applied to two different kinds of surrogacy.

A last case is noteworthy because it gives the opportunity to ponder about how complex could be the issue of parenthood in surrogacy.

In re Marriage of Buzzanca (1998)[188] involves a couple, John and Luanne Buzzanca who decided to try with a gestational surrogacy to have children, because they could not have their own.

They used the gametes from anonymous donors to create embryos, which were implanted in a surrogate mother.

Before the birth of the baby the Buzzancas' marriage failed, and Luanne claimed the court that the baby, not born yet, was the

188 *In re Marriage of Buzzanca (1998)* 61 Cal.App.4th 1410 Available at:http://law.justia.com/cases/california/court-of-appeal/4th/61/1410.html

couple's child, instead John said that it was not true. He did not want to be legally or financially responsible for a baby who was not genetically related to him neither born by his former wife.

Therefore the child that could have six potential parents (two intended parents; two donors; the surrogate mother and her husband) was left with no parents. In fact the trial court agreed with John, ruling that the child had no legal parents.

The Court of Appeal, reversed the sentence pronounced by the precedent court, stating that this case was different from all previous ones decided by the Californian courts. Quoting the *Johnson v. Calvert* case, the court had to decide for the best interest of the child, so it was not possible to apply a law that could make a baby a legal orphan. The court concluded that John and Lorraine were the legal parents of the child, because they started the procedure with the intention to become intended parents.

The judgment established that people, who are unable to conceive and decide to turn to artificial procreation, with the intent to be parents, they will be held to the status of legal parents regardless the genetic relationship between them and the babies.

California allows commercial surrogacy, as well as regularly reinforces agreements with regard to gestational surrogacy[189].

The latest law approved in California about surrogacy is the California Law AB-1217[190] which came into force on 1 January 2013.

The new legislation provides additional guidance relating to the manner in which surrogacy agreements must be enforced, when medical procedures can begin, and where parental establishment cases may be filed.

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189 California Family Code, Section 7960-7962

190 Full text available here: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120AB1217

The law makes it possible for all intended parents (regardless of their marital status and/or their sexual orientation) to establish legal parental rights prior to the birth of their children, without the need to go through applications for adoption with the pre-birth order. The pre-birth is used to inform everyone that the intended parents are the legal parents, even if they do not give birth to the child. It becomes effective from the moment of the birth not before, as it is explained by the California Family Code at Section 7633.

The time frame to obtain a judgment can take several months so the lawyers recommend to apply for the pre-birth order after the third month of pregnancy. This judgment puts also the surrogate mother in a safe position, leaving her out of the parenthood responsibility. She will not have after the birth any right on the conceived child.

The hospital, if there is a pre-birth order, has to put the name of the intended parents on the birth registration form of the child born from a surrogate. Once this has been done, the registrar will forward the paperwork to the California State Department of Vital Records, where the baby's birth certificate will be produced, and the child will always have two parents as in a “normal” conception.

3.2.2 MASSACHUSETTS

In Massachusetts there are no laws regulating surrogacy directly.

The people who make an agreement with a surrogate, take the risk that a court might state later that the contract has no value. Nevertheless the court cases have demonstrated to be in favor of surrogacy and in Massachusetts the agreements are equally legal. In particular, the surrogacy arrangements are realized through the application for a pre-birth order, which establishes the future parental

situation of the baby who will be born from surrogate, without the requirement to appear in front of a court.

However it is necessary to examine the State court cases in order to find out how surrogate maternity has been dealt with up today.

The two major judgments which show the validity of the pre-birth orders in the State are: *Culliton v. Beth Israel Deaconess Medical Center*[191] and *Richard I. Hodas v. Kimberly Morin*[192].

In *Culliton v. Beth Israel Deaconess Medical Center* the Massachusetts Supreme Judicial Court reviewed a surrogacy agreement between Marla and Steven Culliton, the intended parents, and Melissa Carroll, the carrier. This was a case of gestational surrogacy where the surrogate was implanted with the embryos created using the Cullitons' gametes. For her role, the gestational carrier received a certain financial compensation, which was not conditioned *"upon the termination of any parental rights or the placement of the child with [the plaintiffs]"*.

The Cullitons sought a declaratory judgment to require the hospital to list them, and not the gestational mother, as the parents of the twins with the support of the surrogate. The three parties here agreed that Cullitons were the biological parents of the twins, and should also be the legal parents of them. But for the court it was not an easy decision to make. The district court dismissed the declaratory concluding that it is not possible for the court to grant a pre-birth order of parentage. Under Massachusetts statutes, the court can issue an order of adoption declaring that the adoptive parents also are the legal parents of a child, but it cannot be done before the birth of the child[193].

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191 *Culliton v. Beth Israel Deaconess Medical Center ;*435 Mass. 285 (2001). Available at: http://masscases.com/cases/sjc/435/435mass285.html

192 *Richard I. Hodas v. Kimberly Morin;* 442 Mass. 544 (2004). Available at: http://masscases.com/cases/sjc/442/442mass544.html

193 Mass. General Laws, Part II, Title III, Chapter210, Section2. Available at:

The Supreme Judicial Court, however, found these statutes to be inapplicable to the Culliton case.

The twins born were considered as the children of the Culliton couple, because what the Supreme Court underlined was the genetic relationship between the babies and the spouses.

If the case had concerned a traditional surrogacy, in which the carrier would have had a biological as well as a gestational relationship with the children, this decision would not have been possible for the applicants, and the court would have had to issue a post-birth adoption order.

In conclusion for the Supreme Judicature Court a district court has the power to grant a pre-birth order of parentage where the plaintiffs are the only genetic parents of the children, the carrier agrees with the solution and the plaintiffs have waived every contradictory provision in the agreement.

This judgment, it is possible to apply only in the presence of these requirements indicated by the court not in any other situation where surrogacy treatment is involved.

The other noteworthy case was *Richard I. Hodas v. Kimberly Morin*[194] concerning, as the previous one, a heterosexual couple genetically linked with the baby born under surrogacy. Here it was discussed the validity of the agreements, signed in Massachusetts, between the parties, to facilitate the request to obtain a pre-birth order. The choice to undergo the surrogacy in a Massachusetts' hospital and to sign an agreement in that State, was dictated only by the parties' intent to follow the Massachusetts law even though none of them resided here.

The situation the court was confronted with was the following: the plaintiffs, who were married, lived in Connecticut; the gestational

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https://malegislature.gov/Laws/GeneralLaws/PartII/TitleIII/Chapter210/Section2

194 Id. 192

carrier and her husband, lived in New York; the hospital was a licensed hospital of Massachusetts.

The problem of the court was to decide between the possibility of the parties to decide to be judged by Massachusetts law and the fact that States were they lived had a different public policy about assisted reproduction. In Connecticut, gestational carrier agreements are not overtly prohibited, and may be applied through the recently amended statute governing the issue of birth certificates. In New York there is a strong public policy against all gestational carrier agreements, and in Massachusetts, following the case of *Culliton v. Beth Israel Deaconess Med.* the surrogacy agreements are allowed in some circumstances.

The court decided that:

> "*[w]here the parties have expressed a specific intent as to the governing law, Massachusetts courts will uphold the parties' choice as long as the result is not contrary to public policy.*"

The judge explained that in this situation they are not facing a problem of "forum shopping" so for the best judgment of the case the court has to refer to Massachusetts provisions.

The Supreme Court remanded the settlement of the case to the Probate and Family Court to declare in the pre-birth order that the intended parents were the legal parents of the unborn child.

This was possible because the entire procedure of surrogacy took place in Massachusetts, including the surrogacy contract. It would not have been the same if the couple had requested the court to give validity to a surrogate situation taking place outside the State.

Today there are no judgments of the State courts on homosexual people, but looking at the fact that the access to surrogacy is allowed also to them under the same conditions, it is assumed that these people have the same opportunity given to heterosexuals.

The limits about surrogacy in Massachusetts are based on the genetic relation between the foetus and the parent. This restrains the liability to demand a pre-birth order, which requires a blood relationship between the intended parents and the unborn child. If the prerequisite the court can issue a post-birth order, after just four days to the birth, provided that a valid surrogacy agreement stipulated in Massachusetts is enforced.

The last possibility, for those who cannot apply for the birth orders, is to start a procedure for the adoption of the child.

FINAL REMARKS

The results of this study have confirmed the existence of two different procedures for the legal regulation of heterologous fertilisation and surrogacy in the UK and the USA.

The UK legislator chooses to operate with a regulatory framework for all procedures. Medical activities or research carried out in the field of fertility must be authorised by the HFEA and all clinics must be registered with the HFEA to practice ART.

The premise of the English legal approach is based on the fundamental principles of the well-being of the patient and the child from any fertility procedure.

Surrogacy is the only treatment which does not have a comprehensive ruling, but since all other areas are so strictly regulated, it is likely to have a homogeneous legislation for this reproductive technique in the near future.

It is only studying heterologous fertilisation and surrogacy in the US that the immense differences between the two countries become apparent. The extensive regulations which provide lawyers and physicians a solid foundation to operate on in England do not exist in the US.

Initially it was difficult to locate provisions regarding assisted reproduction in the United States, its legal system is vastly different to that of England. It was not possible to ratiocinate like an Englishman, it was necessary to enter into the American way of thinking to fully understand the reasoning behind the US rulings in fertility techniques.

The US legislation leaves its citizens the freedom to act in deciding to procreate or not. This is based on a constitutional interpretation about the right to privacy. Some studies about US behaviour on assisted reproduction refer to it as the "Wild West" because it is an

industry worth thousands of millions of dollars with very little regulation. Lawyers and specialists in ART are criticized this term: they underline that in the silence of the law, other regulations at Federal level have closed the gap between law and standard practice. At the same time each of the US States, in the last twenty years, has started to enact its own regulations to give a legal response to ART patients and to regulate the status of the new families that these procedures have created. Therefore talking about a "Wild West" nowadays would not be correct. In the US the system does not lack regulation, the government prefers to regulate only the necessary, leaving the States free to decide how to rule on fertility procedures.

The words “Wild West” could be used however, in reference to the economic question. In the US the free market policy allows the clinics to determine prices paid to the donors and to surrogate mothers. The US approach allows the practice of ART on a commercial basis, where as in the UK only the expenses incurred by donors and surrogates can be reimbursed. This American policy also has an effect on the cost paid by the ART applicants and consequently, costs in the US are higher than those in England.

In the UK there is no financial gain to be made from these treatments. The imposition of monetary restrictions in England is often debated in newspapers, with claims that donating or being a surrogate mother are commitments that should be adequately reimbursed. Once again the US decision to substantially compensate donors and surrogates, shows a wide difference with the UK.

It is not possible to think that a country as vast as America with so many different States could adopt the same legal rulings for all, even more so when we consider that assisted reproduction is still today such a highly contentious topic under many aspects.

The legislator has allowed the US States and their citizens the freedom to regulate ART and the practices associated with it. The

states of California and Massachusetts, on which this thesis was focused, are two of many that have applied these regulatory procedures in their territories.

It would appear that these two States have decided to rule on many of the questions related to assisted reproduction. For now the State Courts and laws have attempted to define the best situation regarding the judicial issues of ART, balancing the fundamental right to privacy with the rights of any party involved in the practice of fertility techniques.

Given the ongoing development of these technologies and the impact they have on society and therefore on the rights of the individual, it would not be wrong to say that it is only a matter of time before the Federal legislature will be confronted with the need to create a uniform regulation.

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